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Integrating a System Approach to Identify and Manage Aggressive Behaviors in Adult Males with Severe Mental Illness in a Psychiatric Hospital

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INTEGRATING A SYSTEM APPROACH TO IDENTIFY AND MANAGE AGGRESSIVE BEHAVIORS IN ADULT MALES WITH SEVERE MENTAL ILLNESS IN A PSYCHIATRIC HOSPITAL

by

Mitzie Alford-Jenkins

Abstract of a Capstone Project
Submitted to the Graduate School
of The University of Southern Mississippi
in Partial Fulfillment of the Requirements
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ABSTRACT

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Aggressive behaviors exhibited by patients with a serious mental illness (SMI) hospitalized in inpatient psychiatric hospitals are a challenging safety problem. Early identification of aggressive behaviors is vital to helping nursing staff develop proactive interventions that focus on prevention. Structured risk assessments identify the level of risk and allow for early interventions.

The purpose of the doctoral capstone project was to: (a) provide education to nursing staff on implementing a structured risk assessment tool in order to identify risk for imminent aggression, manage risk for imminent aggression, and record aggressive behaviors among adult males with severe mental illness (SMI); (b) implement the structured risk assessment tool; (c) determine by retrospective chart review if the structured risk assessment tool is used by nursing staff to identify and manage patients with moderate or high risk for aggression; and (d) evaluate nursing staff's perspective of the usefulness of the structured DASA-IV tool in a psychiatric hospital.

Nursing staff conducted a continual assessment over a four-week period in which the DASA-IV risk scores were documented, prevention plans were implemented, and aggressive behaviors were recorded for seven days on all newly admitted patients with a diagnosis of SMI. A retrospective chart review was conducted to determine if the DASA-

IV was completed correctly, and an evaluation survey was administered to determine the nursing staff's perspective of the usefulness of the tool.

The nursing staff found the DASA-IV tool useful in practice and information on the tool to be useful in identifying risk for imminent aggression and recording aggressive behaviors. Of the twenty risk assessments conducted, all were completed correctly by the nursing staff documenting the risk score and rating, implementing a crisis intervention or risk management plan based on the risk rating, and recording aggression.

The results of this project demonstrate that through an evidence-based system approach, the addition of a structured risk assessment instrument for appraising risk for imminent aggression in a psychiatric hospital may assist nursing staff in the initiation of preventive interventions to manage aggressive behaviors.

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DEDICATION

Above all, the author would like to thank Jesus Christ, who makes all things possible.

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LIST OF ABBREVIATIONS

AHRQ	Agency for Healthcare and Research Quality
APNA	American Psychiatric Nurses Association
APRN	Advanced Practice Registered Nurse
AUC	Area under the curve
CPPS	Center for Personal Protection and Safety
DASA-IV	Dynamic Appraisal of Situational Aggression-Inpatient Version
DNP	Doctor of Nursing Practice
DSM-V	Diagnostic and Statistical Manual of Mental Health Disorders
ECA	Epidemiologic Catchment Area
IOM	Institute of Medicine
IRB	Institutional Review Board
LPN	Licensed Practical Nurse
MSH	Mississippi State Hospital
N=	Sample
n=	Population
n.d.	No date
NGC	National Guideline Clearinghouse
NIMH	National Institute of Mental Health
NIOSH	National Institute of Occupational Safety and Health
OHE	Optimal Healing Environment
OSHA	Occupational Safety and Health Administration
RN	Registered Nurse

SHARP	Safety and Health Assessment and Research Prevention
SMI	Severe Mental Illness
U. S.	United States
USM	University of Southern Mississippi

CHAPTER I

INTRODUCTION

Aggressive behaviors in inpatient psychiatric hospitals presents a complex and challenging safety problem in clinical practice (Cutcliffe & Riahi, 2013a; Cutcliffe & Riahi, 2013b; Grenyer et al., 2004; McPhaul, London, & Lipscomb, 2013). Nursing staff works in close proximity of patients with severe mental illness (SMI) being treated in inpatient psychiatric hospitals who are aggressive and potentially violent (National Institute for Occupational Safety and Health [NIOSH], 2004). Evidence suggests that there is a clinically important relationship between adult males with severe mental illness, such as schizophrenia or schizoaffective disorders, and aggressive behaviors in psychiatric hospitals (Anderson & West, 2011; Douglas, Guy, & Hart, 2009; Stuart, 2003). Despite known causes and implementation of interventions to potentially prevent and treat aggressive behaviors in psychiatric hospitals, high incidents of aggressive behaviors continue to occur in psychiatric hospitals (American Psychiatric Nurses Association [APNA], 2008; Center for Personal Protection and Safety [CPPS], 2011).

Evidence suggests that staff and patients' perspectives on the causes of aggressive behaviors exhibited by patients hospitalized in psychiatric hospitals differ (Dickens, Piccirillo, & Alderman, 2013). Studies examining the perspectives of adult males with severe mental illness as the cause of aggressive behaviors reveal that they perceive staff interpersonal communication and the lack of therapeutic environments as the main causes of aggressive behaviors in psychiatric hospitals (Dickens et al., 2013; Duxbury & Whittington, 2005; McPhaul et al., 2013). While nurses also recognize the negative impact of the lack of a therapeutic inpatient environment on patients' behaviors in

psychiatric hospitals, in comparison, they view the patient's psychiatric diagnosis as the main reason for aggressive behaviors (Duxbury & Whittington, 2005). Thus, behavioral interventions continue to focus on the patients' aggressive behaviors alone and fail to take into account the patients' perspectives of the causes of aggressive behaviors. Inevitably, aggressive behaviors continue to occur frequently in psychiatric hospitals. A system approach that acknowledges the perspectives of both the staff and patient may potentially prevent the number of aggressive behaviors in psychiatric hospitals (APNA, 2008). Recent evidence suggests that if environmental conditions and poor communication is acknowledged from the patients' perspectives and incorporated into behavioral interventions, aggressive behaviors by individuals with a diagnosis of severe mental illness may potentially be prevented (McPhaul et al., 2013).

If acknowledged, it is postulated that eventually change in hospital policies based on best practices for managing aggressive behaviors in individuals with a diagnosis of severe mental illness will be generated with a resultant decrease in the number of aggressive incidents, staff and patient injuries, and ultimately staff turnover. Addressing aggressive behaviors in psychiatric hospitals requires purposeful organizational processes conducted within very specific organizational structures (McPhaul et al., 2013). The utilization of a systems approach that is holistic and focuses on the patients' perspectives as well as the staffs' perspective of causes of aggressive behaviors in adult males with severe mental illness may prevent aggressive behaviors in psychiatric hospitals.

Background and Significance

Aggressive behaviors in adult males with severe mental illness are an ever-present multidimensional, complex problem that includes many contributing factors (Cutcliffe &

Riahi, 2013b, p 558). Aggressive behaviors towards staff working in psychiatric hospitals have physical and emotional effects and are a principal cause of staff injuries in psychiatric hospitals (Ilkiw-Lavalle & Grenyer, 2003). Aggressive behaviors directed towards staff who work in psychiatric hospitals is an ever-present risk that requires prevention and management interventions to decrease the risk and provide for the safety of the staff, as well as the patients (Anderson & West, 2011; Taylor, 2013).

The United States Occupational Safety and Health Administration (OSHA) estimates that each year 2,600 non-fatal assaults occur on hospital staff (CPPS, 2011). The healthcare sector leads all other industry sectors in incidence of nonfatal workplace assaults with 48% of all non-fatal injuries occurring from aggression against. One 2009 workplace violence survey found that almost half of all non-fatal assaults in the United States were exhibited by healthcare patients (CPPS, 2011). Aggressive behaviors against healthcare staff cause serious physical injuries as well as psychological trauma. Non-fatal aggressive attacks on healthcare workers often result in lost time from work. These injuries include assaults, bruises, broken bones, concussions, lacerations and other physical injuries (U. S. Department of Labor, Bureau of Labor Statistics, 2005). Along with physical injury, healthcare workers may also suffer short- and long-term psychological trauma, fear, changes in relationships, feelings of incompetence, guilt, powerlessness, and fear of criticism by co-workers (Occupational Safety and Health Administration [OSHA], 2004). Recent studies suggests that aggressive behaviors in the healthcare sector is not only a dangerous and complex occupational hazard in today's healthcare sector, but it is often tolerated and explained as just part of the job (McPhaul et al., 2013; Rueve & Welton, 2008).

According to the report, "Crossing the Quality Chasm: A New Health System for the 21st Century," there is an increasing need for healthcare that is safe, effective, efficient, and patient-centered (Institute of Medicine [IOM], 2001). Thus, today's healthcare delivery system should be creative and foster innovation to improve the quality of patient care. Redesigning the healthcare delivery system to improve the quality of patient care will require changing the structures and processes of the healthcare environment in which health professionals and organizations function. One of the ten rules for redesign is safety as a system priority (IOM, 2001).

Safety

Safety is the main issue of concern for registered nurses (RNs) working in close proximity of patients with a diagnosis of severe mental illness in psychiatric hospitals (APNA, 2008). Furthermore, the risk for violence is higher for nursing staff than in any other setting (Erdos & Hughes, 2001; Privitera, Weisman, & Cerulli, 2005; Sheridan, Henrion, Robinson, & Baxter, 1990). Approximately 500,000 nurses are victims of aggressive behaviors in the workplace (U.S. Department of Justice, 2008; as cited in APNA, 2008, p. 8). Nurses experience workplace aggression at a rate of 72% higher than medical technicians and at more than twice the rate of other healthcare professionals. Fear of aggressive behaviors exhibited by patients has been associated with poor job satisfaction; further, workplace aggression has resulted in multiple worker's compensation claims and high staff turnover rates. Recent increases in workplace aggression, especially in the healthcare sector, have resulted in policy initiative programs that require organizations to develop and implement training programs to prevent aggressive behaviors in the office (APNA, 2008). Without a provision of support,

education, and training programs that address prevention and intervention techniques, policies alone cannot effectively reduce the incidence of workplace aggression (APNA, 2008). Early identification of aggressive behaviors is vital to helping nursing staff develop proactive interventions that focus on prevention.

Mental health workers experience the highest rate of assaults in the healthcare sector, with 68.2 assaults per 1,000 workers (Ahuja, 2006, p.24; as cited in APNA, 2008). Members of interprofessional teams, including nursing staff, nurse practitioners, physicians, and other healthcare professionals, who work in psychiatric hospitals where patients exhibit aggressive behaviors are at risk for verbal abuse, injury, short- and long-term complications, and death (APNA, 2008; Grenyer et al., 2004; Rueve & Welton, 2008; Stuart, 2003; Tishler, Gordon, & Landry-Meyer, 2000). Although nurses experience the most assaults, physicians, pharmacists, nurse practitioners, physician assistants, nurses' aides, therapists, technicians, home healthcare workers, social/welfare workers, and emergency medical care personnel are all at risk of aggression by patients. Psychiatric units are particularly dangerous, as are emergency rooms, crisis and acute care units, and admissions departments (OSHA, 2004).

The risk for aggression is greater for physicians and nursing staff employed in psychiatric hospitals. The risk of aggression for psychiatrists, when treating mentally ill patients, is more than four times greater than the risks facing other physicians (general medical physicians' rates of nonfatal, job-related violence are 16.2 per 1, 000 and psychiatrist and mental health professionals are 68.2 per 1,000)**.** Similarly, psychiatrists have a five to 48% chance of being assaulted by a patient during their career, and 40 to 50% of psychiatric residents will be physically attacked by a patient during their four-

year training program (APNA, 2008; Fiedman, 2006; Rueve & Welton, 2008; Stuart, 2003; Taylor, 2013).

Psychiatric nurses experience the highest violent victimization rates of all types of nurses (Safety and Health Assessment and Research Prevention [SHARP], n.d.). The rate of assault injuries to psychiatric nurses in particular (16 victimizations per 100 employees) exceeds the annual rate of all injuries reported in most high-risk occupations (CPPS, 2011). On average, 69,500 assaults against psychiatric nurses occur annually (NIOSH, 2004). Staff surveys suggested, in one study, that the annual rate of nonfatal violent crime for nurses was 21.9 (80% of the nurses were subject to violent crime during their career). The rate of other mental health workers was 40.7. Compared with the nonfatal crime rate for all workers, healthcare professionals, and especially mental health workers are at heightened risk for becoming victims of violence (Simon, 2011). Sadly, the U.S. Department of Labor, Bureau of Labor Statistics (2005) reported incidents in which three hospital RNs and five psychiatric and home health aides died as a result of violent acts of aggression that year.

Aggressive behaviors are one of the most complex and risky hazards facing nurses in the psychiatric healthcare environment today. Washington House Bill 2899, passed in 2000 to address violence in healthcare, requires psychiatric hospitals to offer employees violence prevention training at least annually and to implement procedures for reporting and responding to physical and verbal aggression (SHARP, n.d.). Independently, in 2008, OSHA and the Joint Commission released new standards requiring administrators to provide effective leadership in addressing issues of aggressive and violent behaviors in the workplace (Janocha & Smith, 2010).

Policy

All organizations should have in place a set of policies and procedures relating to the management of aggressive and violent behaviors, and these policies should be updated to reflect the most current evidence-based practice procedures and guidelines. An effort to prevent aggressive behaviors in psychiatric hospitals has contributed to the missions of NIOSH and OSHA (NIOSH, 2002, OSHA, 2004; as cited in APNA, 2008). Recently, employees have been provided resources from studies conducted on aggression in the workplace. At the policy or "system" level, few states have workplace violence prevention laws, which suggest that hospitals need to develop programs. However, there may be regulations that impede some workplace violence prevention strategies (McPhaul et al., 2013). At the state level, only California, Washington, Florida, Illinois, New Jersey, Tennessee, and Nevada have passed laws requiring special violence prevention protection in healthcare workplaces. Thus, many healthcare organizations adopted a "zero-tolerance" policy approach related to workplace violence (APNA, 2008). However, evidence suggests that there are problems with a zero-tolerance approach to aggression and management training (Middleby-Clements & Grenyer, 2006). One study found that a zero-tolerance approach, potentially had unintended consequences of increasing rigid or inflexible attitudes toward the management of aggression in the healthcare setting workplace, while reducing tolerance toward aggression (Middleby-Clements & Grenyer, 2006). Inflexible attitudes can create even more problems when trying to de-escalate an aggressive patient. When de-escalating an aggressive patient, healthcare staff should offer choices to give the patients a sense of control. However, an inflexible staff limits the number of choices offered. Thus, interventions for managing aggressive behaviors should

be holistic and utilize a systems approach while acknowledging the patients' perspectives (Cutcliffe & Riahi, 2013a; Cutcliffe & Riahi, 2013b).

Healthcare Costs

Healthcare organizations have an enormous financial incentive to prevent and manage aggression in the workplace. The indirect cost associated with workplace aggression has major implications for the health of the healthcare staff and the organization. Healthcare costs include recruitment and retention costs, increased staff absence from work, reduced efficiency and performance at work, reduced staff morale, reduced staff numbers and especially loss of experienced staff (leading to increased pressure on remaining staff), decreased permanent nursing staff, high incidence of patient complaints, higher risk of increased frustration by patients and staff, higher risk of aggressive incidents, falling reputation for the organization, and increased staff turnover (APNA, 2008; Gates, Gillespie, & Succup, 2010; James, Fineberg, Shah, & Priest, 1990). Direct cost related to patient and staff injuries due to workplace aggression include lost revenue for payment of worker's compensation claims for missed time from work, payment for overtime or hiring temporary staff to cover those missed shifts, hospital bills for staff injuries, hospital bills for patients' injuries, and litigation for unsafe work environments (CPPS, 2011).

Needs Assessment

As a result of multiple complaints of aggressive behaviors on an acute psychiatric unit at a psychiatric hospital in rural Mississippi, structured focus groups and interviews were conducted by the project director to gather staff's perspectives of the causes of aggressive behaviors and solutions to manage risk for aggressive behavior (Nursing staff,

personal communication, April 18, 2014). The need for therapeutic communication between patients and staff, a therapeutic environment for patients, and support and proactive interventions for staff were affirmed after the project director witnessed multiple incidents of aggression. It is the opinion of the project director that patients' aggressive behavior was a direct consequence of staff provocation, unmet patient needs, inflexibility, and inadequate staff training. In the adult male unit at the psychiatric hospital, multiple aggressive incidents resulted in a chemical or mechanical restraint for patients due to inflexibility of the staff and the staff's failure to communicate. Each of these incidents could have possibly been prevented with therapeutic communication or perhaps flexibility on the behalf of the staff.

A lack of a therapeutic environment also contributed to many of the acts of aggression in this psychiatric hospital. Unit rules were often unenforced unless a tragic accident occurred. In a structured focus group with nursing staff conducted by the project director, information was shared regarding an incident where an employee suffered a severe injury as a result of non-adherence to environmental rules. As a consequence, there were multiple staff resignations and a worker's compensation claim, thus, further affirming the potential benefit of the implementation of a structured risk assessment that identifies patients at risk for aggressive behaviors and the resultant initiation of crisis prevention and risk management plans. The suggested crisis prevention plan for moderate risk of aggressive behaviors and risk management plan for high risk of aggressive behaviors would prepare the staff on therapeutic communication with the patients, warning signs to observe for in potentially agitated patients, and interventions to initiate in crisis situations.

Work environments with aggressive interactions between patients and staff, negatively impact staffs' health and wellbeing and are associated with a reduced quality of care and recruitment and retention problems within the healthcare organization (APNA, 2008). Additionally, evidence supports this inconsistency in the way in which unit rules are conducted or communication of rules in a negative manner, can have a significant influence on aggressive behaviors (McPhaul et al., 2013).

A lack of education and training on warning signs for potentially aggressive behaviors for staff is another area that has significantly contributed to aggressive behaviors (Dickens et al., 2013). Recently, educational training and orientation have decreased at the psychiatric hospital where the project was implemented. Despite various staff injuries with clear evidence of inadequate training, the educational training for employees at the psychiatric hospital usually consisted of three day training in the Mandt System Program. The Mandt System (2010) is a comprehensive, integrated approach to preventing, de-escalating, and if necessary, intervening when the behavior of an individual poses a threat of harm to himself and/or others. This program was developed in 1975 when David Mandt, Sr., was asked to design a systematic training program for the staff at residential facilities supporting people affected by intellectual disabilities, developmental disabilities, and mental health, as well as for the staff at community mental health centers. Known today as the Mandt System Program, it is divided into three components—relational skills, conceptual skills, and technical skills—that utilize a cognitive behavioral approach with the belief that philosophy and attitude lead to how individuals behave in both their non-verbal and verbal communities (Mandt System, 2010).

Past research has focused on the person with the mental illness, rather than the nature of the social interchanges that led up to the aggressive behaviors (Cutcliffe & Riahi, 2013a; Douglas et al., 2009). Evidence suggests that even in treatment units with a similar clinical mix, the acuity rates of aggressive behaviors are known to dramatically indicate that mental illness alone is not sufficient cause of the occurrence of aggression in the workplace (Cutcliffe & Raihi, 2013a; Douglas et al., 2009). Most recent studies suggest that aggressive behaviors among persons with severe mental illness are sparked by the conditions of their social life and by the nature and quality of their closest social interactions (Douglas et al., 2009; Stuart, 2003). Patients' characteristics alone cannot completely explain the aggression that occurs in psychiatric hospitals. Certain staff members' characteristics, attitudes, or communication styles may result in staff being targets of aggressive behaviors (APNA, 2008). Conflicting differences in opinions regarding the staff's perspective versus the patients' perspectives of causes of aggressive behaviors can pose a huge problem in psychiatric hospitals. Theories of risk indicate that differences in the perception of risk from an individual, group, or organization can lead to more reckless, careful, or avoidant behaviors (Cutcliffe & Riahi, 2013b).

A need to implement a system for staff to identify patients at risk for behaving aggressively and manage aggressive behaviors through the utilization of an evidence-based structured risk assessment was identified. Evidence indicates that a system approach that acknowledges the perspectives of both the staff and the patient could assist with the identification and management of aggressive behaviors (Cutcliffe & Riahi, 2013b). For this doctoral capstone project, the doctor of nursing practice (DNP) project director determined if an evidence-based system approach that provides education to

nursing staff on implementing a structured risk assessment tool for adult males with severe mental illness (SMI) improves identification and management of patients at risk for aggression in a psychiatric hospital.

Review of Related Literature

A review of the literature was conducted to identify an evidence-based practice solution to preventing and managing risk for aggressive behaviors in adult males with severe mental illness in a psychiatric hospital. This literature review was conducted utilizing the following databases: National Guideline Clearing House, the Agency for Healthcare and Research Quality (AHRQ), Cochrane, PubMed, Ebscohost, MEDLINE, and CINAHL. The search terms "adult males with severe mental illness," "aggressive and violent behaviors," "inpatient state psychiatric hospitals," and "system approach" were used to conduct the literature review.

Risk Factors

A number of studies have examined the relationship between severe mental illness and aggressive behaviors. In an Epidemiologic Catchment Area (ECA) study, the National Institute of Mental Health (NIMH) evaluated the rates of various psychiatric disorders and found that patients with severe mental illness were two or three times as likely as people without severe mental illness to exhibit aggressive behaviors (National Institute of Mental Health [NIMH], 2011). In a study conducted in a locked, short-term psychiatric inpatient unit that involved 374 patients, consecutively admitted over a one-month period, the most significant risk factor for physical aggression one month before admission was associated with a past history of physically aggressive behaviors and persistent physical assaults before and during hospitalization and was related to higher

Brief Psychiatric Rating Scale statistical scores and more severe thought disturbances; higher levels of hostility-suspiciousness scores predicted a change for the worse in aggressive behaviors, from verbal to physical (Amore et al., 2008). In a study conducted by Bowers, Allan, Simpson, Nijman, and Warren (2007), there was a significant relationship between aggressive behaviors and psychiatric admissions and particularly of male patients. This study also found that most aggressive behaviors occurred within the first days of admission. Also verbal aggression appeared to be related to males with an increase in the number of admissions in psychiatric hospitals.

Other risk factors for aggressive behaviors include young, male, single, of low socioeconomic status, severe mental illness, readmissions, and involuntary admissions (Anderson & West, 2011; Rueve & Welton, 2008; Stuart, 2003). Included in the more significant association of physical aggression were male sex, substance abuse, and positive symptoms of schizophrenia. Positive symptoms of schizophrenia include abnormal thoughts and perceptions including delusions and hallucinations, and disorganized speech and behavior (APA, 2014).

A diagnosis of schizophrenia or psychosis has been associated with high risk behaviors (Cutcliffe et al., 2013b). A study conducted over a six-month period, to identify novel risk factors that assist staff in identifying and managing risk for aggression in psychiatric inpatient populations, averaged 285 aggressive behaviors (as recorded) and 111 incidents of physical aggression toward people. Over 75% of the patients had a primary diagnosis of severe mental illness (Ogloff & Daffern, 2006). Additional studies have identified adult males with severe mental illness as the most aggressive patients in

psychiatric hospitals (Anderson & West, 2011; Douglas et al., 2009; Faulkner, Grimm, McFarland, & Bloom, 1990; Stuart, 2003).

A prior history of aggressive behaviors (especially in inpatient settings) is another high risk indicator for potentially aggressive behaviors in adult males with severe mental illness. Evidence indicates that between 10 and 30% of hospitalized psychiatric patients have engaged in aggressive behaviors prior to admission (Cutcliffe & Riahi, 2013a). Rueve and Welton (2008) reported that patients who reported more than three psychiatric readmissions were two to four and a half times more likely to also report aggressive behaviors when compared to participants who reported only one diagnosis.

Although the potential for conflict and aggressive behaviors in psychiatric hospitals where patients are admitted involuntarily is probably inevitable and a consequence of providing psychiatric treatment for patients, early detection of patients at high risk for aggression can aide in the proactive initiation of crisis prevention plans, thus, improving the management of aggressive behaviors (Ogloff & Daffern, 2006).

Though some studies found a clear statistical association between certain diagnoses and higher risk of aggression, other studies did not. Elbogen and Johnson's (2009) discovered that so-called "severe mental illness" is not a robust predictor of aggressive behavior. People experiencing severe mental illness report histories of mental illness and also mental stressors associated with elevated risk of aggression; "severe mental illness" alone is not an independent contributor to explaining aggressive behaviors (Cutcliffe & Riahi, 2013b). Severe mental illness has been found in some studies (Douglas et al., 2009; Stuart, 2003) to indicate increased risk, and inversely, to indicate no increased risk in other studies (Cutcliffe & Riahi, 2013b).

Staff's Perspective

Duxbury and Whittington (2005) found significant differences between staff and patients' attitudes regarding aggressive behaviors. Many patients suggested that external and interactional or situational factors were responsible for aggressive behaviors. In contrast, staff attributed aggression to internal causes (Duxbury & Whittington, 2005), and they approved controlling approaches to management, such as medications, physical interventions, and restraints (Dickens et al., 2013). One study evaluated the views of patients and staff involved in aggression in psychiatric hospitals to help identify causes, understand emotions and perceptions of the cause, and make recommendations to reduce the frequency of aggressive behaviors. A total of twenty-nine staff and twenty-nine patients from four psychiatric inpatient units were involved in forty-seven incidents of aggression over a four-month study period. Many staff members perceived the patient's illness as the cause of aggression, and more staff than patients suggested improving medical management as a means of reducing aggressive behaviors (Ilkiw-Lavalle & Grenyer, 2003). A lack of training on therapeutic communication and warning signs to assess for aggressive behaviors may negatively affect staff attitudes toward the management and treatment of aggressive psychiatric patients, thereby creating a less than optimal therapeutic environment for these individuals (Antonius, Fuchs, & Herbert, 2010).

Some nurses believe the level of risk in a potentially aggressive scenario does not stem solely from factors within the patient but also reflects external factors, such as the skills of staff, the ability to work effectively in a team, the presence of others who could escalate aggressive behaviors, and the availability of weapons. This information indicates

that some nurses agree with the identified factors specific to the patient relationship, which include knowing the patient, understanding the patient's frame of reference, recognizing the impact the severe mental illness has on the patient, being aware of the patient's aggressive history, observing the situation, and identifying patterns of behavior leading to aggression (APNA, 2008).

Patients' Perspectives

An overwhelming amount of literature indicates that patients have identified the lack of therapeutic environment and interpersonal or therapeutic communication as the main causes of aggressive behaviors (Dickens et al., 2013; Duxbury & Whittington, 2005; McPhaul et al., 2013; Ilkiw-Lavalle & Grenyer, 2003). In the aforementioned studies, nearly all patients emphasized the need for improved staff- patient communication and more flexible unit rules in helping reduce aggression. Typically, patients perceive staff behaviors as being more coercive than the staff members think they are (APNA, 2008). Requests, power struggles, and/or controlling staff behaviors has been repeatedly identified as the main cause of aggressive behaviors in patients with a diagnosis of severe mental illness (Cutcliffe & Riahi, 2013a; Panayiotopoulos, Pavlakis, & Apostolou, 2013). One study found that the presence of interpersonal factors, such as hurtful or abrasive words, disagreements, and invasion of personal space, were more commonly identified as reasons for aggressive behaviors than internal factors, and results indicated 60% of aggressive behaviors were preceded by at least one threatening or intrusive behavior (APNA, 2008).

In a study that interviewed male psychiatric patients being treated in a maximum security unit and involved in aggression, 61% classified being teased or bugged as the

reason for aggressive behavior (Fagan-Pryor et al., 2003). Love and Elliot (2002) gathered information about male forensic patients' opinion of the cause of aggression and suggestions for solutions; they identified two main causes of aggression as social hazards of environments and provoking staff- patient interactions (this included staff who do not consider patients' unmet needs and the manner in which privileges are granted and revoked). This also included staff changing medications or punishing patients for speaking up and staff granting favors or attention unequally (Fagan-Pryor et al., 2003). In one study forensic inpatients agreed with staff about the use of de-escalation and other non-invasive techniques such as the need for improved communication or better one-to-one relationships (Dickens et al., 2013). Patients agreed with a statement that staff not listening was a contributing factor to aggression, while staff views were more neutral (Duxbury & Whittington, 2005; as cited in Dickens et al., 2013).

Patients' view illness factors as the cause of aggressive behaviors much less often than the staff, and patients and staff almost equally report limit setting as a cause of aggressive behaviors (APNA, 2008). In a study that aimed to identify patients' perceptions of the cause of aggressive behaviors and patients' recommendation for interventions to prevent assaultive behaviors, the participants indicated that both patients and staff play an important part in causing and in intervening to prevent violence (Fagan-Pryor et al., 2003).

Despite known causes of aggressive behaviors, most patients receive chemical (medical) restraints and loss of privileges, and often times require seclusion and/or physical restraints due to perceived aggressive behaviors. These interventions have mostly proven ineffective in the attempt to decrease and prevent aggressive behaviors in

patients with severe mental illness, often making the situation worst. There is consensus in the scientific evidence that care for aggressive behavior is multidimensional and complex, but there has been little evidence of attempts to adopt a corresponding multidimensional systems approach in spite of the positive outcomes from the previous studies (Cutcliffe & Riahi, 2013a).

System Approach

A system approach attempts to view the individual as a whole. It focuses its attention on the whole, as well as on the complex interrelationship among its constituent parts. The system theory integrates the perspectives of all contributing factors: patient health history, socio-demographic issues, social isolation, stereotypes, abuse history, mental severity, multiple hospitalizations, present mental state [psychosis], and the patients [and their mode of operation]. The theory is designed to assist in understanding the overall phenomenon that contributes to the patients' aggressive behaviors and increases the risk for aggressive behaviors (Institute of Medicine [IOM], 2001).

Responding to aggressive behaviors requires multiple strategies with a need for comprehensive evidence-based training that educates staff members about how they can actively participate in preventing as well as managing aggressive behaviors (Grenyer et al., 2004). Interactions typical on inpatient units, such as limit setting, denying a request, gaining compliance, involuntarily medicating someone, and de-escalation, are associated with aggressive behaviors and emphasize the importance of mental status assessment skills, therapeutic communication competency, unit environments, and nurse- patient relationships (APNA, 2008). Communication strategies that incorporate the identification of risks and the acknowledgement of patients' perspectives of what causes aggressive

behaviors may reduce the potential for harm to staff and patients caused by aggressive behaviors (Ogloff & Daffern, 2006; Taylor, 2013). The project director proposes a systems approach that focuses on a structured risk assessment to identify the risk for aggressive behaviors and implementation of a crisis prevention and risk management plan for adult males with severe mental illness in a psychiatric hospital.

Risk Assessments

Aggressive behaviors have important implications for appropriately assessing risk of danger in managing therapeutic relationships (APNA, 2008). Nursing staff and other mental health professionals are expected to be able to identify and manage imminent risk or danger and predict the potential for aggressive behaviors (APNA, 2008). When treating patients with severe mental illness, there are many different static and historical variables to consider. The most recent generation of prediction research employed actuarial methods to measure the relative contributions of specific evidence-based variables categorized as either "static" (fixed and historical factors) or "dynamic" (changeable). Static factors such as gender, history of violence, childhood experiences, and behaviors are not subject to change (Ogloff & Daffern, 2006). This approach to risk assessment vastly improved the accuracy of predicting aggressive behaviors. Static or historical factors alone have consistently been found to be more accurate than dynamic factors. A history of violence remains the single most important predictor of aggressive behaviors in psychiatric settings (APNA, 2008; Anderson & West, 2011; Rueve & West, 2008). A study conducted to analyze violence risk assessment on an inpatient psychiatric unit was conducted twice daily for the first three days of hospitalization in patients with acute psychiatric symptoms and found that risk assessments significantly prevented

aggressive behaviors on the unit (Abderhalden et al., 2008). The main outcome measures were the changes in rates of severe aggressive incidents and coercive measures comparing the baseline period with the intervention period. There was a reduction in the incidence rate of coercive measures and severe aggressive incidents, suggesting that structured risk assessments may be a simple and cost-effective way of preventing the problem of aggressive behaviors in psychiatric hospitals (Abderhalden et al., 2008).

Structured short-term risk assessment can improve clinical decision-making and can result in timely de-escalation actions, thus avoiding intrusive coercive interventions such as seclusion, restraint, and forced administration of medications (Linaker & Busch-Iversen, 1995). Sheridan et al. (1990) suggested that nursing staff may place too much emphasis on the control of aggressive behaviors through restraining medication, seclusion, and physical restraints at the cost of examining a means of prevention. Long-term attempts to intervene through changing behavioral patterns may be more beneficial. A structured risk assessment is a low-cost intervention that has been proven to be effective in diminishing aggressive behaviors (Sheridan et al., 1990).

Dynamic Appraisal of Situational Aggression- Inpatient Version [DASA-IV]

In light of multiple attempts to delineate the demographic and clinical characteristics of high-risk psychiatric patients and identify modifiable aspects of aggression-prone environments, some research methods showing acceptable predictive validity in their ability to inform day-to day treatment and management decisions are limited. Patient factors are those risk factors associated with a patient's mental state, attitudes, and behaviors. These factors have been shown to be particularly important in the assessment of inpatient aggression and form the basis of the DASA-IV. The DASA-

IV has been found to have good predictive validity for identifying dynamic risk factors that are subject to change and inform the likelihood of aggression in the short-term (Allnutt, O'Driscoll, Ogloff, Daffern, & Adams, 2010).

Because risk within the inpatient setting fluctuates, often by a minute by minute assessment, it is important to conduct structured risk assessments and implement management strategies when observable behavior changes in a patient suggest potential increased risk of aggression is emerging. Any patient with a history of significant interpersonal aggression warrants a structured risk assessment and risk management plan. Risk assessment begins with empirically known patient-centered risk factors and ends with an implemented plan to effectively manage those risk factors. However, a risk assessment is never complete without the implementation, documentation, and communication of the risk management plan to others. Thus, risk assessment and management is not a single event but a process, because risk fluctuates and continually changes. Therefore, a person's risk can change rapidly over a short period of time, which is a clear indication that dynamic changes need to be monitored over a period of time. The purpose of the risk assessment is to provide the foundation for and guide the development of the risk management plan (Allnutt et al., 2010).

Early detection and interventions with individuals at risk of behaving aggressively are widely recognized as the key to improved management of inpatient aggression (Griffith, Daffern, & Godber, 2013). Early warning signs can be identified through the assessment process and warn staff of emerging risk. The utilization of a crisis prevention plan can ensure that this important information is clearly available to others involved in the patient's care (Allnutt et al., 2010).

Structured risk assessment tools, such as the Dynamic Appraisal of Situational Aggression-Inpatient Version (DASA-IV) have proven to be effective for appraising risk for imminent aggression in inpatient psychiatric hospitals (Barry-Walsh, Daffern, Duncan, & Ogloff, 2012; Griffith et al., 2013; Ogloff & Daffern, 2006). The DASA-IV is a structured measure that is used by nursing staff to assist in assessing the risk of imminent (within the next twenty-four hours) aggression for patients in inpatient psychiatric hospitals. The DASA-IV can be administered during regular daily routines by trained nursing staff; therefore, it is cost effective. The DASA-IV is easy to use (usually utilizing a check-box approach) and takes less than five minutes to complete. The assessment should be completed by primary nursing staff, preferably 7 a.m. to 3 p.m. shift and completed between the hours of 2 to 3 p.m. (mid-day), so that the information can be passed on to the oncoming shifts. The primary shift 7a.m. to 3 p.m. should also record any records of aggression the following day prior to the completion of the DASA-IV (Ogloff & Daffern, 2006). The DASA-IV tool consists of dynamic items that have the potential to be addressed in daily psychiatric management and treatment plans. The DASA-IV is a seven-item scale that was developed and tested by Ogloff and Daffern (2006), drawn from research and other scales, and was proven to be more accurate in predicting aggressive behaviors than nurses' clinical judgments alone (APNA, 2008). It is composed of seven items: negative attitudes, impulsivity, irritability, verbal threats, sensitive to perceived provocation, easily angered when requests are denied, and unwillingness to follow directions. These seven items are all independently related to aggression. The DASA-IV also has the potential to prevent aggression, through the identification of warning signs of escalation, thus decreasing staff injuries and days

missed from work while increasing hospital staffing and revenue. A development study of the DASA-IV was shown to predict aggression within twenty-four hours with an area under the curve (AUC) of .82 (Ogloff & Daffern, 2006).

In a study that aimed to determine whether imminent aggression in psychiatric inpatients can be accurately predicted using a structured risk assessment instrument (Dynamic Appraisal of Situational Aggression- Inpatient Version [DASA-IV]), a validation study involved 10,013 DASA risk assessments of patients residing in a psychiatric hospital; twenty-four hours after the risk assessment psychiatric nurses documented whether patients had behaved aggressively toward others. The predictive validity of the DASA varied according to the type and target of aggression. The prediction of any aggressive behavior, irrespective of type of aggression, was significantly greater than chance with an AUC of 0.69 with the strongest predictive accuracy AUC of 0.80 for physical aggression toward staff. Results suggest that imminent aggression in psychiatric hospitals can potentially be accurately predicted by psychiatric nurses using the DASA-IV instrument (Barry-Walsh et al., 2012).

Although there is a lack of research about the possible contribution of a structured risk assessment to the reduction of aggression in psychiatric hospitals (Abderhalden et al., 2008), risk assessments that evaluate violence potential may be a crucial first step in predicting and preventing aggressive and assaultive behaviors in patients with severe mental illness and should be an important element of treatment and management consideration (Antonius et al., 2010).

Risk assessments are an essential part of treating patients with severe mental illness because they can be easily incorporated into the patients' treatment plan. Risk

assessments assist with identifying patients at moderate or high risk for aggressive behaviors and the need for facilitating a crisis prevention or risk management plan. Crisis prevention and risk management plans have been known to be effective treatment interventions for patients with aggressive behaviors (SCCMHA, 2005).

Crisis Intervention and Risk Management Plan

For this project, nursing staff was trained on the use of the (DASA-IV) tool. The project director utilized a systems approach that included the implementation of the DASA-IV. A crisis prevention plan and risk management plan were implemented for adult males with severe mental illness in a psychiatric hospital that were identified as moderate or high risk for aggressive behaviors based on the score of the DASA-IV. Opportunities for helping patients learn skills to manage their illness and teaching strategies for reducing relapse and coping with symptoms should be the focus of group and individual interventions with the goal of placing the patient in charge of his or her illness and set personal goals for recovery (SCCMHA, 2005).

According to the National Guideline Clearinghouse (2011), recommendations from the APA guidelines include reducing the use of physical interventions (such as seclusion and restraints) while at the same time maintaining the safety of patients and staff and includes a crisis prevention plan as an intervention. Interventions such as assessing for anger management problems, identifying risk factors, identifying triggers, involving patients in treatment planning, asking patients about past experiences, and documenting attempted interventions should be implemented before the use of physical interventions (NGC, 2011). Evidence-based crisis prevention plans are currently being utilized in the psychiatric hospital in which this project was conducted. This crisis

prevention plan was to be discussed with each patient with a moderate risk for aggressive behaviors.

A crisis prevention plan, when utilized in a team approach, is a successful prevention strategy and provides procedures for identifying and addressing observable behaviors that have the potential to elevate to concerns. A strong organizational focus and emphasis on the observation and reporting of behaviors that generate concern, coupled with efficient and consistent responses to the behavior, can help create a safer work environment for the patients and staff (OSHA, 2004). Risk management must be built on recognition of the patient's strength and with emphasis on recovery. Risk management plans should include the identified risk, actions to be taken in response to a crisis, and should be based on assessment using structured clinical judgment approaches (Department of Health, 2007). According to OSHA (2004), a risk management plan should establish "time-out" or seclusion areas with high ceilings without grids for patients who "act out;" provide comfortable patient waiting rooms designed to minimize stress; ensure that adequate and properly trained staff is available to restrain patients, if necessary; provide sensitive and timely information to people waiting in line for medications, meals, and/or transport to and from group activities; adopt measures to decrease waiting time; and ensure that adequate and qualified staff is available at all times (the times of greatest risk occur during patient transfers, emergency responses, mealtimes, and at night). Areas with the greatest risk include admission units and crisis or acute care units.

Therapeutic Environment

The care-giving work environment is a complex and dynamic environment, making it difficult to isolate a single risk factor or a single hazardous condition. This environment itself includes many inter-related components such as the experience and training of the staff in handling aggressive behaviors, the job demands and pace of work, staffing levels, and levels of overtime (McPhaul et al., 2013). The current healthcare system must achieve major gains in safety, effectiveness, patient-centeredness, timeliness, and efficiency, in an effort to create a safer healthcare environment and improve the patient's quality of care (IOM, 2001). To ensure and promote quality and a culture of safety, healthcare organizations must address the behaviors that threaten the performance of the healthcare team (Joint Commission, 2008). External events, primarily a conflict with staff or another patient, are more commonly perceived as precipitants by patients as causes of aggressive behaviors (APNA, 2008). The immediate environment can either raise or lower an individual's level of dangerousness, and nursing staff behaviors function as antecedents and consequences to aggression (APNA, 2008). Evidence indicates that a therapeutic environment can aid in containing aggression, and it is essential to catch the patient in the earlier stages leading up to aggression and provide some measure of control to de-escalate potentially aggressive patients (Rueve & Welton, 2008; as cited in Ogloff & Daffern, 2006). The utilization of structured risk assessments designed to identify individuals at risk of behaving aggressively through the identification of static and historical risk factors can assist nursing staff with identifying patients at moderate or high risk for aggressive behaviors and the need for facilitating a crisis prevention plan for moderate risk and a risk management plan for high risk.

Observation and reporting of changes in behaviors that become a concern are critical. Communication, collaboration, and teamwork by the staff as well as documenting and reporting aggressive behaviors are imperative in a system approach.

Otto (2000) states monitoring of behaviors can assist with the identification of exacerbations of symptoms and treatment interventions (such as environmental interventions that are designed to reduce the likelihood of risk potential being increased, removal from stressful environment, and removal of weapons or other means of violence from the patient) that can follow in response to this increased risk. All staff involved in risk management plans should receive relevant training and must be capable of demonstrating sensitivity and competence, which are essential components of therapeutic communication (Department of Health, 2007).

Therapeutic Communication

A major barrier to awareness and prevention of workplace aggression is an overall lack of adequate therapeutic communication and effective training for interprofessional nursing staff. In the pursuit of individual responsibilities and tasks, the importance of effective therapeutic communication may be overlooked or given a low priority among competing demands (APNA, 2008). Although there is limited research on limit-setting communication styles, the evidence suggests that some communication styles could potentially stimulate high levels of anger and should be avoided in patients who are unwilling to accept denials of request and who are easily angered by demands for activity (Ogloff & Daffern, 2006).

The therapeutic relationship is central to the practice of psychiatric or mental health nursing (Shattell, Starr, & Thomas, 2007). Staff members who are unfamiliar with

the population they are supervising need supervision and training that highlight the need to identify warning signs and understand patients' perspectives (Ilkiw-Lavalle & Greyner, 2003) as well as a need to be knowledgeable and understanding. Further education and training on severe mental illness and therapeutic communication could result in the development of more positive attitudes for interprofessional nursing staff in a mental health setting (Panayiotopoulos et al., 2013).

Intervention strategies such as using a zero-tolerance approach have been proven ineffective and possibly contribute to aggressive behaviors. In a time when aggressive behaviors in the workplace are at a staggering high, management and prevention strategies still neglect an obviously helpful solution to the problem, incorporating the patients' perspectives. In one study clients were reported to desire therapeutic relationships with nurses and other healthcare providers. They wanted nurses to really know them and to incorporate time, understanding, and skills in their cares (Shattell et al., 2007). Wagoro, Othieno, Musandu, and Karani (2008) state the following regarding patient satisfaction with care:

> Patients' satisfaction with care included being happy with attention from nurses, nurses listening to patients when talking with them, nurses providing patients with information about illness and information on medications prescribed, participation in ward activities, and access to recreational facilities. These findings were indicative of the process of caring, which is an essential ingredient of interpersonal relationships and was highly linked to positive patient outcomes. (p. 250)

Currently, most interventions focus on de-escalation and perceive patients' mental illnesses as the main source of aggression. It is essential to understand the patient, structure of the organization, and familiar population of the healthcare services, and develop an appreciation of the system perspective (McPhaul et al., 2013). Recent evidence indicates that a systems approach, which acknowledges the perspectives of both the staff and patient could prevent the number of aggressive behaviors in psychiatric hospitals (APNA, 2008). The U. S. Department of Health and Human Services (DHHS, 2011) recommends a structured clinical judgment approach to risk assessments, multidisciplinary working, well-thought-out and well-imparted training, and clear procedures on communicating risk as the best practice in managing risk. Regular process evaluations and team feedback on risk identification and critical thinking about best interventions would improve the level of decision-making in psychiatric hospitals (van de Sande et al., 2011).

Education about expectations of treatment on the unit and improved therapeutic communication between nursing staff and patients could potentially reduce aggression in patients who are unwilling to accept limits or respond to the demands of inpatient treatment angrily. It is paramount to patient care to sufficiently train nursing staff to identify precipitants of aggressive behaviors as well as effective therapeutic communication to manage aggressive behaviors exhibited by patients (Anderson & West, 2011).

Summary of Review of Related Literature

The project director identified an evidence-based systems approach that included the implementation of a structured risk assessment, so staff could identify patients at risk

for imminent aggression and manage risk for aggression as identified in the review of the literature (Appendix M). Structured risk assessments can identify patients who are at increased risk of aggression and assist staff in the implementation of a crisis prevention plan for patients with moderate risk and risk management plan for patients with high risk for aggression in a psychiatric hospital. Patient-centered crisis prevention and risk management plans (with recommendations for instituting a therapeutic environment, improving therapeutic communication among nursing staff and patients, and acknowledgement of the patients' preference for prevention of aggression) could assist in de-escalating and managing aggressive behaviors. The crisis prevention and risk management plans were implemented for adult males with severe mental illness in a psychiatric hospital in Mississippi who were identified as moderate or high risk by scoring the DASA-IV for aggressive behaviors.

Responding to aggressive behaviors requires multiple strategies with a need for comprehensive evidence-based training that educates staff members about how they can actively participate in preventing as well as managing aggressive behaviors (Grenyer et al., 2004). Interactions typical on inpatient units, such as limit setting, denying a request, gaining compliance, involuntarily medicating someone, and de-escalation, are associated with aggressive behaviors and emphasize the importance of mental status assessment skills, therapeutic communication competency, unit environments, and nurse-patient relationships (APNA, 2008). Communication strategies that incorporate identification of risks and acknowledgement of patients' perspectives of what causes aggressive behaviors may reduce the potential for harm to staff and patients caused by aggressive behaviors (Ogloff & Daffern, 2006; Taylor, 2013). Nursing staff and other mental health

professionals are expected to be able to identify imminent dangerousness and predict the potential for future aggressive behaviors (APNA, 2008). Risk management is a core component of mental healthcare. Effective care includes an awareness of a person's overall needs as well as an awareness of the degree of risk that he or she may present to himself or herself or others.

The integrative formulation of a structured risk assessment with recommendations for crisis prevention and risk management plans to identify and manage aggressive behaviors in adult males with severe mental illness, aids in understanding the patient as a unique human being and allows the clinician to appreciate the patient's environment, strengths, challenges, and coping skills (NGC, 2011) (strategies listed in the patient's crisis prevention plan from the patients' perspective). An additional component of the formulation includes an assessment of the patient's risk of harm to self or others. The risk assessment is intended to identify the patient's degree of risk, thereby suggesting specific interventions (NGC, 2011) such as a crisis prevention plan for moderate risk of aggression and risk management plan for high risk for aggression.

Psychiatric nurses play an important role in the identification of risk factors for aggression and violence and the implementation of interventions that promote and maintain safety (APNA, 2008). Many nurses make decisions every day about how to help a patient with severe mental illness manage his or her potential for aggression and violence, self-harm, suicide, or self-neglect while hospitalized in a psychiatric hospital.

Nurses must endure the challenge of identifying a framework that is evidence-based and provides structure, as well as consistency across psychiatric settings. Identification and management of risk are conducted through the process of structured

risk assessments with identification of risk factors to address the safety of the patient and the staff (NGC, 2011). This consistency is essential for good communication among patients, staff, and healthcare providers. A consistent approach to risk management when utilized by nursing staff will enable better communication and contribute to improved quality of care.

Theoretical Framework

The nursing profession recognizes that the integration of all dimensions of healing into the administration of patients' care potentially provides personal empowerment and can result in a significant impact on prevention and management of healthcare problems (Mahoney, Palpyo, Napier, & Giordano, 2009). The term *optimal healing environment* (OHE) was developed in 2002 by the Samueli Institute (Samueli Institute, n.d.). To explain the component of an OHE, a framework "was developed and defined as one in which the social, psychological, spiritual, physical, and behavioral components of healthcare are oriented towards support and stimulation of healing and the achievement of wholeness" (Samueli Institute, n.d., p. 4). Using a system approach as an optimal healing environment based on continuous healing relationships, patient-centered care, and safety as a system priority provides a framework to organize care in a holistic manner that supports positive patient outcomes (Mahoney et al., 2009). Therefore, the optimal healing environment framework is suitable for the treatment of today's psychiatric healthcare environment. This approach provides a platform for nurses and other clinicians to explain the ways of an environment traditionally limited to the unit environment to one that includes a broader system (Mahoney et al., 2009). System thinking is essential for managing patients with severe mental illness in today's psychiatric healthcare

environment (IOM, 2006a). The OHE extends from the internal environment to the broadly external environment through reciprocal interaction. An OHE is composed of four major characteristics: the internal, interpersonal, behavioral, and external environment (Jonas & Chez, 2004, pp. S1-S6).

- The internal environment consists of the goals of developing healing intentions (a conscious determination to improve the health of another person or oneself); and experiencing personal wholeness (this occurs when the body, mind, and spirit are at peace and working harmoniously).
- The interpersonal environment consists of cultivating healing relationships (a reflection of the social and professional interactions that foster a sense of belonging, well-being, coherence, and healing. Healing relationships are intentional, adaptable, cohesive, covenantal, and reciprocal in nature. The nurturing of healing relationships is one of the most powerful ways to stimulate, support, and maintain wellness and recovery); and creating healing organizations (which support a healing culture through their mission, vision, and values. A successful healing organization has a strategic plan for fostering team work and patient-centered care, leadership support for healing initiatives, stable funding, and an evaluative culture that is flexible and resilient).
- The behavioral environment consists of practicing healthy lifestyles (healthy behaviors can enhance well-being and prevent, treat, or even cure disease); and integrative care (applying collaborative medicine). Collaborative medicine is team-based care that is person focused and family centered to treat the whole person).

- The external environment consists of building healing spaces (spaces designed to optimize and improve the quality of care, outcomes, and experiences of patients and staff); and fostering ecological sustainability (which can be achieved by reducing the carbon footprints and supporting the health of the planet. The goal is to consider energy utilization, chemical impact, and resource intensity in all decisions, and replace products or processes with more ecologically friendly, less harmful and cruelty-free alternatives).

Components of the internal, interpersonal, and external environments (building healing spaces, developing healing intentions, and cultivating healing relationships) were utilized for this capstone project to create a framework for educating, identifying, and managing aggressive behaviors through the utilization of a systems approach. The capstone project was designed to improve the health outcome of patients with severe mental illness through the recognition of the risk for aggressive behaviors and development of patient-centered interventions based on the identified risk that takes into account the patients' as well as the staff's perspectives of the management of aggression.

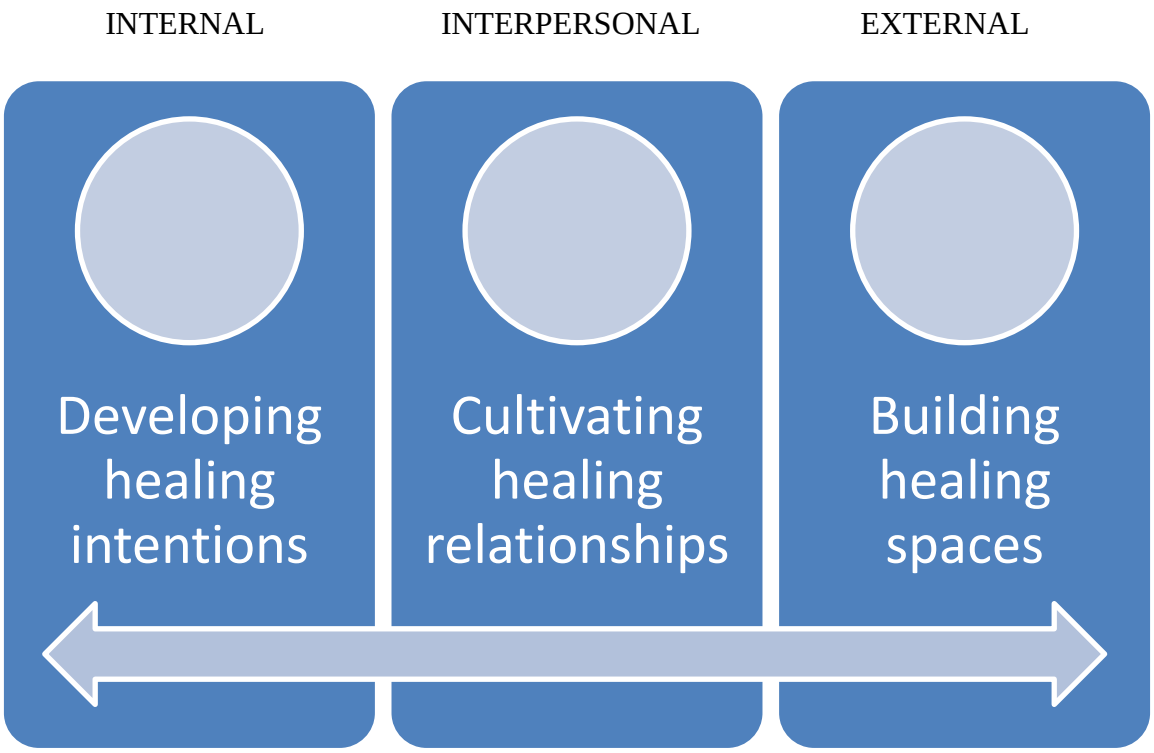

Figure 1. Three project components used to create the optimal healing environment framework.

The internal environment component of the OHE framework, developing healing intentions, is achieved through the utilization of the patients' perspectives, a patient-centered focus that incorporates the patient's personal meaning of the behavior. Risk for aggressive behavior is assessed and individualized interventions based on the risk assessment are designed to manage aggressive behaviors. The interpersonal environment cultivates healing relationships and incorporates the patients' and staff's perspectives. The crisis prevention and risk management plans are patient-centered interventions that view aggression from the patients' and staff's perspectives. A reciprocal relationship exists between the patient and staff to improve therapeutic communication and create a therapeutic environment. Healing relationships are established to assist the patient in recovery. The external environment, building healing spaces, is also an important

component in this capstone project. Interventions are implemented to creating a safer environment for the patients and the staff, thus, reducing patients' risk for aggressive behaviors and patient and staff injuries.

The optimal healing environment framework guided this capstone project because the continual assessment to identify and manage risk for aggressive behaviors in a psychiatric hospital has the potential to improve the therapeutic environment through improving therapeutic communication between the patient and staff. The utilization of a structured risk assessment, crisis prevention plan for moderate risk behaviors, and risk management plan for high risk behaviors can assist in the identification and management of aggressive behaviors utilizing a system approach. The obligation to assess patients with severe mental illness daily for seven days as part of the project intervention can assist in increasing general awareness of potential dangers through scores of moderate or high risk. Patients with scores of moderate and high risk for aggression are to be discussed and reported to oncoming shifts during shift reports. This awareness itself has the potential to foster a more cautious approach in de-escalating patients' behaviors. Through the identification of patients with moderate or high risk for aggressive behaviors, the utilization of a structured risk assessment allows for early identification, which can assist the nursing staff in early interventions such as the implementation of a crisis prevention plan and risk management plan to manage aggressive behaviors. The crisis prevention plan and risk management plan incorporates the external environment, which contributes to the creation of healing spaces, and the internal and interpersonal environments through the reciprocal relationship between the patients and staff while taking into account the patients' perspectives of the best strategies to reduce aggression.

The utilization of therapeutic communication can improve the staff and patient interpersonal relationship. These factors in combination with the obligatory discussion of moderate and high risk situations might have the potential to result in a more consistent team response to potentially dangerous patients and improve the overall safety of the environment.

The distinction of the systems approach to a healing environment is the attempt to create a system that merges implicit values such as empathy with more explicit care issues. This allows for examining the healing environment through a health services perspective. This approach fosters improved communication, collaboration, and increased patient-centeredness (Mahoney et al., 2009). This model emphasis the importance of sensitivity to self and others, the development of therapeutic relationships, the promotion of interpersonal relationships, and provision for a supportive, protective, and corrective mental, physical, socio-cultural and spiritual environment (Mahoney et al., 2009). This project is significant because using a system approach as an optimal healing environment based on continuous healing relationships, patient-centered care, and safety as a system priority provides a framework to organize care in a holistic manner that supports positive patient outcomes (Mahoney et al., 2009).

Doctor of Nursing Practice (DNP) Essentials

The growing complexity of the psychiatric healthcare environment, coupled with the rapid expansion of knowledge required for practice, is the reason advanced practice registered nurses (APRNs) need to deliver patient-centered care as a member of an interprofessional team that emphasizes evidence-based practice, quality improvement, and a systems perspective (IOM, 2006). As a DNP prepared APRN, practicing in

complex systems and organizational levels, potential problems are identified and interventions are developed to address system problems. Therefore, competence in identifying and developing interventions to facilitate healthcare delivery across systems is a key role of the DNP prepared nurse. This doctoral capstone project reflects knowledge and transitional skills in identifying complex healthcare problems, such as the need for prevention and management of aggressive behaviors in inpatient psychiatric hospitals. This doctoral capstone project utilizes a systems approach to develop, implement, and evaluate evidence-based clinical interventions that are directed at prevention and management of aggressive behaviors among adult males with SMI in an inpatient psychiatric hospital. A system approach provides the framework for seeing interrelationships and patterns of change rather than individual issues. The proposed capstone project utilizes principles of practice management, including conceptual and practice strategies for balancing productivity and quality care and identifies the impact of clinical policies and procedures on meeting the health needs of the patient population.

One key benefit of the application of systems thinking in such massive, complex concerns is the ability to deal effectively with a variety of problems from a holistic viewpoint. The systems approach helps raise thinking to the level at which individuals and organizations create results, even in those difficult situations marked by complexity, great numbers of interaction, and the absence of ineffectiveness of immediately apparent solutions. System thinking allows people to gain an explicit understanding of social systems and improve them in the same way that people can use engineering principles to improve their understanding of mechanical systems. Complexity can easily undermine responsibility and creativity and result in feelings of helplessness and hopelessness.

System thinking has already become significant in healthcare, largely due to the continuous quality improvement initiatives in patient safety. The DNP Essentials for the proposed doctoral capstone project will be met as identified in Appendix A.

Evaluation Plan

At the conclusion of the 4-week project period, the project director anticipates the DASA-IV to be effective in the identification and management of aggressive behaviors in psychiatric hospitals as identified by retrospective chart review and the staff's perspective of the usefulness of the tool. Nursing staff's satisfaction with administering the DASA-IV tool will be measured with a short anonymous survey questionnaire at the conclusion of the project. The project director expects the staff to identify patients at moderate or high risk for aggressive behaviors, thus, contributing to the implementation of a crisis prevention plan for all patients with a score of 1-2 and a risk management plan for all patients with a score of 3 or greater. The evaluation plan is outlined in Appendix B.

Definitions

Aggression was defined as any threatening verbal or physical behavior directed toward objects or people and risks for aggression is defined as irritability, impulsivity, unwillingness to follow directions, sensitivity to perceived provocation, easily angered when requests are denied, negative attitudes, and verbal threats

Severe mental illness is defined as a psychiatric diagnosis of schizophrenia, schizoaffective disorder, and/or psychosis, with or without substance use, abuse, or dependence.

For this project, the project director used the term *aggression* to denote a wide range of behaviors as defined in the DASA-IV.

Assumptions

1. Aggressive behaviors in adult males with severe mental illness are a direct result of the patients' mental illness and are caused by the patients' mental illness.
2. Aggressive behaviors are expected in inpatient psychiatric hospitals and are normal for adult males with severe mental illness.

Purpose

The purpose of this doctoral capstone project is to: (a) provide education to nursing staff on implementing a structured risk assessment tool in order to identify risk for imminent aggression, manage risk for imminent aggression, and record aggressive behaviors among adult males with severe mental illness (SMI); (b) implement the structured risk assessment tool; (c) determine by retrospective chart review if the structured risk assessment tool is used by nursing staff to identify and manage patients with moderate or high risk for aggression; and (d) evaluate nursing staff's perspective of the usefulness of the structured DASA-IV in a psychiatric hospital.

CHAPTER II

METHODS

This doctoral capstone project (a) provided education to nursing staff on implementing a structured risk assessment tool in order to identify risk for imminent aggression, manage risk for imminent aggression, and record aggressive behaviors among adult males with serious mental illness (SMI); (b) implemented the DASA-IV over a four-week study period; (c) determined by retrospective chart review that the DASA-IV assessment tool was used correctly by nursing staff to identify and manage patients with moderate or high risk for aggression; and (d) evaluated nursing staff's perspective of the usefulness of the DASA-IV assessment tool on a unit in a psychiatric hospital.

Setting

The project was conducted on an adult male psychiatric unit in a psychiatric hospital that serves a rural population in southeast Mississippi. The project director chose an adult male psychiatric unit because of the high risk of aggressive behaviors that occurs in this population. The unit has twenty-five inpatient residential beds but is usually overly populated with twenty-six to twenty-eight patients and averages four to five admissions each week. More than half the patients admitted to the unit are diagnosed with a psychotic disorder such as schizophrenia, schizoaffective disorder, or psychosis not otherwise specified as defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-V).

Sample

A convenience sample of full-time registered nurses (RNs) and licensed practical nurses (LPNs) nursing staff that work forty hours a week on the 7 a.m. to 3 p. m. shift

was recruited to participate in this doctoral capstone project. All full-time nursing staff that is permanently assigned to the unit on which the project was conducted were recruited to participate in the project. The 7 a.m. to 3 p.m. shift consists of three RNs and one LPN with a minimum of two or more years of psychiatric experience on the unit, and one RN was hired during the study period. Inclusion criteria were permanently assigned nursing staff that work 40 hours a week, 7 a.m. to 3 p.m. with a minimum of 2 years' psychiatric nursing experience on the unit. Exclusion criteria included nursing staff that was not full-time and full-time nursing staff pulled from other units of the hospital to assist with coverage. Selection criteria included full-time 7 a.m. to 3 p.m. nursing staff because of the frequent contact of full-time nursing staff with patients. The 7 a.m. to 3 p.m. shift was chosen because the structured risk assessment tool that was utilized (DASA-IV) recommended that risk assessments be conducted around mid-day and reported to 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. shifts. Permanently assigned staff were selected because of the potential for increased familiarity with the patients on the unit.

Design

A quantitative research design was used to conduct this capstone project.

Procedures

Permission to perform the project at the psychiatric hospital was obtained from the hospital clinical director, and the protocol for the proposed doctoral capstone project was approved by the Institutional Review Board at the psychiatric hospital in which the project was conducted (Appendix C). Permission was granted by Dr. Michael Daffern, Associate Professor at Monash University, in Australia, and developer (Appendix D) of

the Dynamic Appraisal of Situational Aggression-Inpatient Version (DASA-IV) to utilize the DASA-IV tool in this capstone project (Appendix E). The protocol for the proposed doctoral capstone project was also approved by the Institutional Review Board at The University of Southern Mississippi (Appendix F).

Recruitment

Because the project director is employed at the hospital in which the project was conducted, the unit's nurse manager assisted in the facilitation of the recruitment process to eliminate bias. The nursing staff was informed by the nurse manager at a routine nursing staff meeting of the project's recruitment presentation date and time. Also, informational flyers (Appendix G) were placed in the unit where the project was conducted.

The project recruitment presentation was held at shift change on August 22, 2014, and the date of the presentation was discussed and coordinated with the unit manager to ensure that all possible participants had the opportunity to attend. The presentation was held between the hours of 2 p.m. and 3 p.m. in the conference room in the building in which the unit is located to allow for coverage of the unit during the presentation and attendance of both shifts. While refreshments were served during the project recruitment presentation, nursing staff was informed that the refreshments were not an incentive for participation in the project, but instead were a friendly gesture to aide in their comfort and provide a more social, relaxed atmosphere during the presentation. The nursing staff was also informed that the presentation was not mandatory, there would be no incentives for participation in the project, and those who did not wish to participate in the project could still attend the presentation to receive a refresher course on the identification and

risk management of aggressive behaviors.

Consents

On the day of the project recruitment presentation (August 22, 2014), an oral presentation (Appendix H) was delivered by the project director on the nature of the project. Potential participants were given a copy of the oral presentation prior to the project director explaining the purpose, description, and risk and benefits of the project. Reassurances about anonymity, confidentiality, alternative procedures, and participant assurance were addressed in the oral presentation. Furthermore, participants were informed that participation was voluntary. The project director ensured that all participants knew that they had the right to withdraw from the study at any time without being penalized, by informing potential participants, verbally and in writing, prior to signing the informed consent forms for participation in the project. Potential participants were given the opportunity to ask questions after the oral presentation and prior to obtaining informed written consent to participate in the project. After the oral presentation, written informed consent was obtained from potential participants prior to participating in the project (Appendix I). The nurse manager served as witness to consent by providing a signature and date on the consent forms. After consents were obtained to participate in the project, participants were given copies of the signed consent forms. The original signed consent forms were returned to the project director and placed in a locked file in the project director's office at the psychiatric hospital.

Tool

A structured risk assessment tool for imminent aggression, the (DASA-IV) was utilized in the project. The DASA-IV (Appendix E) is a seven-point rating scale designed

to identify the risk of aggressive behaviors among patients in acute psychiatric settings and is based on knowledge and observations of patients during the previous 24-hour period. Nursing staff participants were provided instructions on how to conduct a risk assessment for aggression on the adult male unit.

According to Vojt, Marshall, and Thomsom (2010), this tool was found to be of good to moderate predictive power and the scale has been validated and is easy to use. The scale consists of dynamic items that have the potential to be addressed in daily psychiatric interventions and treatment plans. Each item is scored dichotomously with 0 indicating no change in behavior, and a rating of 1 suggesting an increase in frequency or severity of risk-related behaviors. Therefore, a score of 0 reflects a very low risk for aggression, scores ranging from 1-2 are seen as moderate risk for aggression, and scores of 3 or more imply high risk for aggression. A recommendation of the implementation of a crisis prevention plan for moderate risk and a risk management plan for a patient score of 3 or greater as this is interpreted as high risk for aggression was made. Completion of the scale takes less than 5 minutes. Validation studies of the DASA-IV have shown the tool to be of excellent predictive power in forensic inpatient settings, with ongoing, cross-cultural, validation studies being conducted on the scale's use in other populations (Ogloff & Daffern, 2006; as cited in Vojt et al., 2010). The DASA-IV assessment should be completed by primary nurses or contact nurses for their patients around mid-day each day. The results of the DASA- IV are passed on to the oncoming shifts during routine shift reports. If an aggressive incident occurs during the 3 p.m. to 11 p.m. or 11 p.m. to 7 a.m. shifts, the incident is documented in the patient's chart. At the conclusion of the twenty-four-hour observation period, the aggressive incident is recorded by the 7 a.m. to

3 p.m. shift on the DASA- IV tool in the designated area prior to rescoring the tool the following day (Ogloff & Daffern, 2006).

Educational Session

After obtaining informed consent from participants, there was a brief educational session on the use of the DASA-IV tool, the importance of documenting results and scoring of the DASA-IV tool, documenting aggressive behaviors, and initiating a plan to manage risk for aggression if the patient was identified as moderate or high risk for aggression. Education was provided on implementing an individual crisis prevention plan on patients that score 1 or 2 on the DASA-IV, indicating moderate risk. An overview of implementing a risk management plan for patients that score of 3 or greater on the DASA-IV, indicating high risk, was discussed.

Crisis Prevention Plan. The recommended crisis prevention plan utilized in this capstone project is completed on all patients during their initial admission assessment (within twenty-four hours of admission). This plan identifies the strengths and weaknesses of each patient and can be easily incorporated into the patient's treatment plan to assist the patient in de-escalating prior to aggression. The plan provides information such as warning signs to observe for, techniques identified by the patient as the most helpful strategies for assisting him or her with de-escalating, and general therapeutic communication techniques that are effective in de-escalation. If a patient scores moderate on the DASA-IV tool, the plan is re-evaluated and discussed with the patient and the patient is encouraged to give input to what will be effective for assisting him or her in de-escalation. The crisis prevention plan can assist in facilitating a calmer environment through the use of therapeutic communication techniques such as simply

listening to the patient, letting him or her know that staff is listening to him or her, and improving the patients' quality of care. However, in spite of a crisis prevention plan, the patients' behavior may continue to escalate, indicating a need for a risk management plan.

Risk Management Plan. A risk management plan is usually developed to help keep small issues from developing into emergencies and should be implemented on patient with a score of high risk on the DASA-IV. Therefore, the project director recommended that the risk management plans build on the materials already provided in the crisis prevention plan. The risk management plan utilized in the capstone project provided warning signs to observe for, patient-centered interventions to implement in response to aggressive behaviors (such as offering quiet time, removing the stimulus, removing potential weapons, increasing the patients level of observation, and ensuring well-trained staff is available to assist if a crisis occurs), and rationales for the suggested interventions. This plan creates a safer environment through therapeutic communication, creating a safer area/space for patient and staff, and improving the patients' quality of care.

Staff members were allowed to ask questions to clarify any doubts they may have for completing the DASA-IV. After all questions were answered, the staff was asked to complete, score, and document the results of the DASA-IV tool on a patient presented in a case study scenario, as well as identify the steps to take if the patient scored as moderate or high risk for aggressive behaviors. The results of the case study scenario were discussed in unison to facilitate questions and understanding of the correct way to complete the DASA-IV tool and the steps to take for patients who score moderate or high

risk. The participants were instructed not to change their answers as this was only a practice session.

Once the scenario was discussed and all questions answered, the staff was then given a final case study scenario to complete. All scenarios were turned in to the project director. These practice assessments were evaluated by the project director to ensure that the staff knew how to properly fill out the tool. On completion of the practice session, the project director determined that the participating nursing staff was able to correctly complete the DASA-IV tool.

Data Collection

After the educational session, nursing staff conducted a continual assessment over a four-week period in which the DASA-IV was completed by the 7 a.m. to 3 p.m. nursing staff for seven days on all patients admitted with a diagnosis of severe mental illness (SMI), schizophrenia, schizoaffective disorders, schizopheniform disorders, and/or any thought, mood, or substance abuse disorders with psychosis as defined by diagnostic criteria and codes. The adult male psychiatric unit in the psychiatric hospital averages four to five admissions each week, and more than half the patients admitted to the unit are diagnosed with an SMI. During the four weeks of the project, data were collected on those patients who met the project criteria. Criteria for the population for whom the project participants were to complete a daily DASA-IV the first seven days of admission were English speaking males between the ages of eighteen and sixty-five with a diagnosis of SMI receiving treatment as usual on the unit, meaning unstructured psychiatric observations and treatment based on clinical judgment only. The DASA-IV was not be completed on patients who were non-English speaking because of potential

communication barriers, which could impose a problem for nurses to identify verbal aggression, as well as possible cultural gestures that may be misinterpreted by the project participants. The assessment was completed mid-day on the 7 a.m. to 3 p.m. shift. Patients with a score of 0 were considered low risk, scores of 1-2 were considered moderate risk and the patients received a crisis prevention plan to be implemented and discussed with the patient, and scores of 3 or greater were considered high risk and patients received a risk management plan to prevent aggressive behaviors. The 7 a.m. to 3 p.m. participating nursing staff reported results of 1 or greater to the oncoming 3 p.m. to 11 p.m. nursing staff during shift reports. The 3 p.m. to 11 p.m. nursing staff passed this information on in the shift report to the 11 p.m. to 7 a.m. nursing staff. The patients were rescored daily for 7 days around the same time (mid-day) by the 7 a.m. to 3 p.m. nursing staff. If a patient with a completed DASA-IV exhibited verbal or physical aggression to self, people, or objects, the incident was recorded in the designated area on the DASA-IV tool, prior to the 7 a.m. to 3 p.m. nursing staff conducting the scheduled DASA-IV daily assessment. If a patient with a completed DASA-IV scored low risk and exhibited aggressive behaviors toward self, people, or objects, the behavior would be documented and the risk management plan implemented to prevent further aggressive behaviors. The assessment took less than 5 minutes to complete on each patient; therefore, there were no restrictions on the normal activity of the participants and patients.

The project director frequented the unit every seventy-two hours to conduct a retrospective chart review on patients with a diagnosis of SMI as identified in the DSM-V criteria and determined if the DASA was being recorded and scored correctly, to monitor the implementation of the crisis prevention plan for scores of moderate risk and risk

management plan for scores of high risk. The project director would also check to see if aggressive behaviors were being documented on the DASA-IV, as it was imperative that the 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. nursing staff document as well as report aggressive behaviors to the oncoming shift. The project director coded the data collected during the chart review using numbers instead of names. A removable orange sticker in the shape of a circle, with numbers written in black with permanent marker, was put in several places on the chart (inside front panel, inside back panel, and outside spine) as well as on the DASA-IV form (in the place of a name). The number was written on the corresponding data collection tool (Appendix J) instead of a name.

At the conclusion of the four-week project period, all participating nursing staff members were administered a survey (Appendix K) to identify whether they felt that the DASA-IV tool was useful in assisting in the identification of patients at moderate or high risk for aggressive behaviors and implementation of a crisis prevention plan or risk management plan to manage risk for aggressive behaviors.

Data Analysis

The results of the data collected on the DASA-IV tool was analyzed using descriptive statistics only to identify the statistical significance of the DASA-IV tool in identifying moderate and high risk for aggression in adult males with SMI. The result of the survey of the staffs' perspective of the usefulness of the DASA-IV in the identification and management of aggressive behaviors in a psychiatric hospital was also analyzed utilizing descriptive statistical analysis only. Due to the small sample size utilized in the project, the data could not be analyzed using a statistical program. Statistical mean and percentages were manually calculated to analyze the results.

Ethical Protection of Human Subjects

A waiver for informed consent was approved (Appendix L) for the retrospective chart review and was restricted to examining DASA-IV forms, documentation of aggressive behaviors, and implementation of individualized risk for aggression plans, which was protected by coding. No interaction with subjects occurred. Limited data were collected from the charts and the DASA-IV tool and coded using a de-identified data process. Data collected from the retrospective chart review were coded on a data sheet developed by the project director utilizing de-identified data. De-identified existing data collected during the retrospective chart review were immediately numerically or categorically coded and entered into an Excel spreadsheet in order to maintain confidentiality. The data entered on the data collection form did not contain any identifying information.

Confidentiality of nurse participants' data was maintained by the utilization of identification numbers instead of names. To ensure confidentiality and anonymity, participant information was protected through the use of codes assigned by the project investigator on the survey data collection form. Data were recorded and summarized by the project director so that subjects cannot be identified directly or through identifiers linked to the subjects. For the ethical protection of the subjects, consent forms and all data collected were stored under double locks at the state hospital by which only the principal investigator had access. The data were locked in a cabinet in the office of the principal investigator (which is also locked) to maintain confidentiality of the information. Data will be destroyed by shredding five years after completion of the project and after the evaluation of the data is complete and results are disseminated.

There were minimal risks of harm to subjects associated with this project. Data were kept confidential and measures were taken to prevent associations with individual subjects; therefore, loss of privacy and breach of confidentiality are low risk. Nurse participants may experience psychological discomfort when completing the structured risk assessment tool due to recollection of an incident where the participant was the victim of the patient-related aggression or violence. If the nursing staff participant experienced psychological discomfort when completing the DASA-IV or implementing a crisis prevention or risk management plan for patients identified as moderate or high risk, the participant was encouraged to telephone the project director. The project director would conduct an interview with the participant to determine if a formal referral to a qualified psychotherapist was warranted, with the participant's permission, to help resolve unresolved trauma.

The data generated through participation in this project could potentially benefit the nursing staff and the patients as they might lead to a change in practice on how aggression is currently being prevented and managed in the unit. The data can also contribute to the development of new policies to ensure safety of both the patients and the staff members. The development of new safety policies could also benefit the organization.

CHAPTER III

RESULTS

The aim of this doctoral capstone project was to educate nursing staff on implementing the DASA-IV tool to identify a patient's level of risk as low (score of 0), moderate (scores of 1 or 2), or high (scores of 3 or greater) on the DASA-IV tool with recommendations for a crisis prevention plan for moderate risk and a risk management plan for high risk for all adult males with a diagnosis of severe mental illness admitted during the 4-week project period in a psychiatric hospital. The project director was charged with the task of determining if the DASA-IV tool was utilized correctly by the nursing staff, as this was the most important aspect of the study. This interpretation was made by retrospective chart review every seventy-two hours during the study period in which the charts were reviewed on a case-by-case basis to determine if the DASA-IV tool was completed and filled out correctly and to ensure that all patients with a score of moderate risk for aggression had a crisis prevention plan implemented and those with high risk for aggression had a risk management plan implemented. Also, the project director reviewed the DASA-IV tools for any recorded incidents of aggression as well as checked the nurse's notes and clinical progress notes for any documentation of aggressive behaviors as compared to the recorded incidents.

The nurses' perspectives of the usefulness of the DASA-IV tool were evaluated using a short anonymous survey in which the nurses answered eight questions to identify their perspectives of the usefulness of the DASA-IV tool to identify aggressive behaviors and the usefulness of the implementation of a crisis prevention plan for patients of scores of moderate risk and a risk management plan for patients with scores of high risk in the

management of aggressive behaviors for adult males with severe mental illness in a psychiatric hospital.

Demographics of Nursing Staff

There are a total of five nurses on the 7 a.m. to 3 p.m. shift. One of the registered nurses was newly hired and in orientation during the study period; therefore, he/she did not meet the criteria for the study. Of the four nurses that met the study criteria, one nurse was out on medical leave at the initiation of the study. Therefore, the sample consisted of three nurses (*N* = 3), two RNs, and one LPN on the 7 a.m. to 3 p.m. shift.

Table 1

Demographics of nursing staff

Variable		n	Percentage
Type of Nurse	RN	2	67.6
	LPN	1	33.3
Gender	Male	1	33.3
	Female	2	67.6
Age	25-35	1	33.3
	36-45	0	0.00
	46-55	1	33.3
	56-65	1	33.3

Sixty-seven percent (n = 2) of the participants were registered nurses, and 33% of the participants were licensed practical nurses, while 33% of the participants were male gender, and 67% were female gender. The age range of nursing staff participants was

evenly distributed except for ages thirty-six to forty-five. All participating nursing staff had over two years of nursing experience on the unit in which the study was conducted.

Survey

The primary analysis examined the nursing staff's perspective of the usefulness of the DASA-IV tool in identifying and managing aggressive behaviors per twenty-four-hour period for seven days. At the end of the four-week study period, a short anonymous survey was given to all study participants to identify the nurses' perspectives of the usefulness of the DASA-IV tool in assessing and managing aggressive behaviors for adult males with severe mental illness. The survey consisted of eight questions (Appendix J), and the nurses rated their response by circling the answer that best described their opinion (5 = definitely yes, 4 = yes, 3 = neutral, 2 = no, 1 = definitely no). The results of this evaluation are given in Table 2. From this table it is readily seen that all nurses agreed with the questions 1, 2, 5, 6, 7 and 8. That is, during the training the nurses felt that the information about the tool was useful for identifying the patient as being of moderate or high risk for aggression. Additionally, the nurses felt positive about the use of the tool as useful in recording the patient's aggressive behavior and that it is relatively easy to use. Furthermore, the respondents also felt that the DASA tool will be useful and would continue to use in their practice. On questions 3 and 4, the respondents either were neutral or disagreed with the question. As far as developing prevention plans for assessing risk, most of the nurses had no opinion about the tool, however, one did not feel that the tool will be beneficial in her practice

The majority (n = 2; 67%) answered neutral to whether the information collected on the tool was useful in identifying the need to implement a crisis prevention plan for

patients with moderate risk for aggression, while 33% did not find the information collected on the tool useful in identifying the need to implement a crisis prevention plan for patients with moderate risk for aggression. All nurses (100%) were neutral to the usefulness of the information collected on the tool to be useful in the need to implement a risk management plan with patients at high risk for aggressive behaviors. The majority of the participants found the tool useful to their practice and would like to continue to use the tool.

Table 2

Training Survey

Question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Question 1- During the four weeks have you found the information on the tool to be useful in identifying patients as moderate risk for imminent aggression?	0	3	0	0	0
Question 2- During four weeks, have you found the information on the tool to be useful in identifying patients as high risk for imminent aggression?	0	3	0	0	0
Question 3- During the four weeks, have you found the information on tool to be useful in identifying need for crisis prevention plan for moderate risk?	0	0	2	1	0
Question 4- During the four weeks, have you found the information on the tool to be useful in identifying need for risk management plan for high risk?	0	0	3	0	0

Table 2 (continued).

Question 5- During the four weeks, have you found the information collected on the tool to be useful in recording patient's aggressive behaviors?	0	3	0	0	0
Question 6- Did you find the DASA-IV to be easy to use?	2	1	0	0	0
Question 7- Overall, did you find the DASA to be useful to your practice?	1	2	0	0	0
Question 8- Would you like to continue to use the DASA-IV in your practice?	0	2	1	0	0

Table 3

Result of the Evaluation of the Use of the DASA-IV

Question	Frequency	Percentage
1 During the four weeks you have been using the DASA-IV too, have you found the information collected on the tool to be useful in identifying patients identified as moderate risk for imminent aggression?		
Definitely No	0	0
No	0	0
Neutral	0	0
Yes	3	100
Definitely Yes	0	0
2 During the four weeks you have been using the DASA-IV too, have you found the information collected on the tool to be useful in identifying patients identified as high risk for imminent aggression?		
Definitely No	0	0

Table 3 (continued).

No	0	0
Neutral	0	0
Yes	3	100
Definitely Yes	0	0
3 During the four weeks you have been using the DASA-IV too, have you found the information collected on the tool to be useful in identifying the need for the implementation of a crisis prevention plan with patients identified as moderate risk for imminent aggression?		
Definitely No	0	0
No	1	33
Neutral	2	67
Yes	0	0
Definitely Yes	0	0
4 During the four weeks you have been using the DASA-IV tool, have you found the information collected on the tool to be useful in identifying the need for the implementation of a risk management plan with patients identified as high risk for imminent aggression?		
Definitely No	0	0
No	0	0
Neutral	3	100
Yes	0	0
Definitely Yes	0	0

Table 3 (continued).

5 During the four weeks you have been using the DASA-IV too, have you found the information collected on the tool to be useful in recoding patients' aggressive behaviors?		
Definitely No	0	0
No	0	0
Neutral	0	0
Yes	3	100
Definitely Yes	0	0
6 Did you find the DASA-IV too be easy to use?		
Definitely No	0	0
No	0	0
Neutral	0	0
Yes	1	33
Definitely Yes	2	67
7 Overall, did you find the DASA-IV to be useful to your practice?		
Definitely No	0	0
No	0	0
Neutral	0	0
Yes	2	67
Definitely Yes	1	33
8 Would you like to continue to use the DASA-IV in your practice?		
Definitely No	0	0

Table 3 (continued).

No	0	0
Neutral	1	33
Yes	2	67
Definitely Yes	0	0

Table 4

Overall Mean

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	3.75	**2**	**66.7**	**66.7**	**66.7**
	4.00	**1**	**33.3**	**33.3**	**100.0**
	Total	**3**	**100.0**	**100.0**	

Administration of the DASA-IV Tool

Of the twenty-three patients that were admitted with a diagnosis of severe mental illness during the four-week study period, twenty of the DASA-IV assessments tools (*N= 20*) were administered. One was eliminated because the patient's diagnosis was changed from schizophrenia, paranoid type, to intermittent explosive disorder prior to the completion of the seven-day assessment. Another tool was eliminated because the patient was discharged within five days of admission. Another DASA-IV tool was misplaced on the chart after the initiation of the assessment, and skipped two days of assessment. A retrospective chart review was conducted by the project director to determine if the structured risk assessment tool was used correctly by nursing staff to identify and manage patients with moderate or high risk for aggression. All of this assessment data was

reviewed at the end of the study. This review was made to determine if the nurses were using the assessment tool properly. After careful review, it was deemed that the proper use of the tool was employed by each of the three nurses doing the evaluation. Of the twenty assessments utilized in the study, all tools were completed correctly by documenting the risk score and rating, implementing a crisis intervention or risk management plan based on the risk rating, and recording aggression. Table 5 below displays the patient assessment values for this study.

Table 5

Assessment Tool

	N	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Average
1. How many low risk?	20	12	15	14	14	14	15	15	14
2. How many moderate risk?	20	6	2	4	5	5	4	4	4
3. How many high risk?	20	2	3	2	1	1	1	1	2
4. How many crisis prevention plans for moderate risk?	20	6	4	5	5	3	3	3	4
5. How many risk management plans for high risk?	20	3	3	2	1	1	1	1	2
6. How many recorded incidents of aggressive behaviors	20	5	0	0	0	0	0	0	<1

Day 1. Twelve of the twenty patients' results from the DASA-IV assessment tools revealed that 60% of the patients were identified as low risk for aggressive behaviors. Six of twenty (30%) were classified as moderate risk, and crisis prevention plans were initiated on each of these six patients classified as moderate risk. However, one of the six patients was later reclassified as high risk for aggression after he exhibited an incident of aggression (verbal aggression against a person). A risk management plan was implemented for this patient after the aggressive incident. Two of twenty (10%) were classified as high risk for aggressive behaviors, and a risk management plan was implemented for these patients. The number identified as high risk for aggressive behaviors was later changed to three after a patient that was originally scored as moderate risk for aggressive behaviors was aggressive and was rescored and classified as high risk. There were five reported incidents of aggression on day 1. However, only four of the twenty patients (20%) were responsible for the aggressive behaviors. Two incidents of aggression were rescored for the same patient on day 1.

Day 2. Of the six patients identified as moderate risk on day 1 for aggressive behaviors, one of the patients was changed to high risk (the aforementioned patient with the aggressive incident) totaling three of twenty (15%) at high risk for aggression on day 2. Three of the patients were changed to low risk for aggressive behaviors; fifteen of twenty (75%) were scored as low risk on day 2. Only two of the twenty patients (10%) were scored as moderate risk for aggression on day 2, and the crisis prevention plan was ongoing for these patients. While these two patient scores did not decrease, there were no reports of aggression; therefore, the crisis prevention plan could have been effective in

preventing aggressive behaviors in these patients. There were no recorded incidents of aggression on day 2.

Day 3. Fourteen of the twenty patients (70%) scored low risk, four of twenty (20%) scored at moderate risk, and two of twenty (10%) scored at high risk. Crisis prevention plans were initiated for all patients at moderate risk, and risk management plans were ongoing for all patients at high risk. There were no recorded incidents of aggression on day 3.

Days 4 and 5. Fourteen of twenty (20%) scored low risk for aggression, five of twenty (25%) scored moderate risk of aggression with new crisis prevention plans implemented on patients newly scored as moderate and ongoing plans for those who were previously scored as moderate, one of twenty (0.05%) scored high risk for aggression and the risk management plan was ongoing for this patient. Again, there were no recorded incidents of aggression on day 4 or 5.

Day 6 and 7. Fifteen of twenty (75%) scored low risk for aggression, four of twenty (20%) scored moderate risk of aggression with an ongoing crisis prevention plan for those who were previously scored as moderate, one of twenty (0.05%) scored high risk for aggression and the risk management plan was ongoing for this patient. There were no recorded incidents of aggression for day 6 or 7.

Summary of Findings

Of the twenty patients observed by the trained nurses, on the average fourteen or 70% of the patients were typically classified by the implementation of the DASA Tool as being of low risk, four or 20% were classified as moderate risk, and two or 10% were classified as high risk. Furthermore, the average number of crisis prevention plans issued

was four for moderate-risk patients and two for high-risk patients. Figure 2 represents the pie chart of the distribution of assessments.

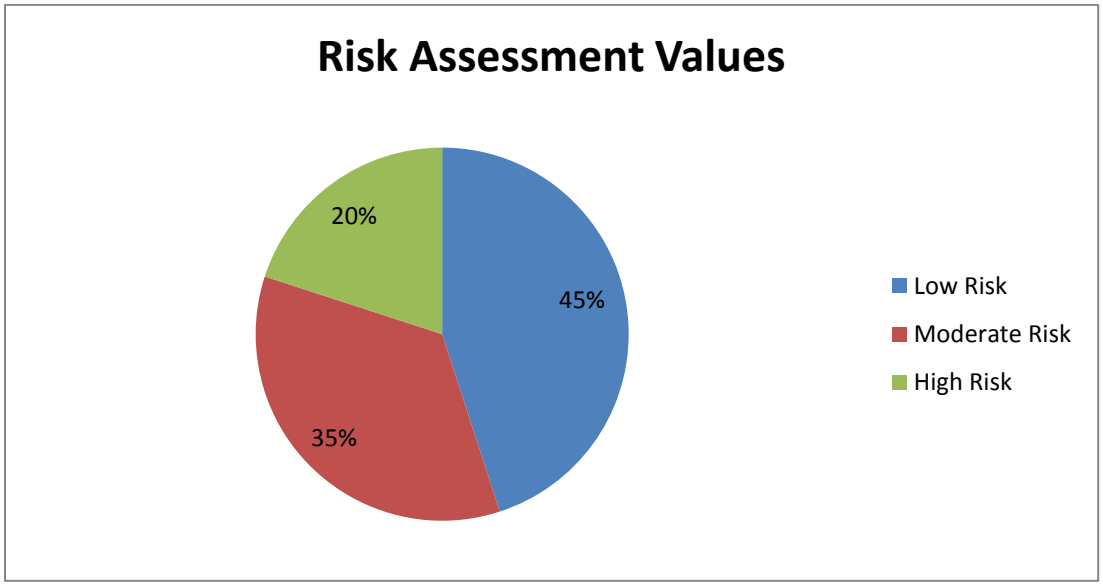

Figure 2. Chart of Risk Assessment Values.

Of the 55% of patients with a rating of Moderate risk or High Risk for aggressive behaviors that required a crisis prevention or risk management plan, all of the patients received the corresponding plan. Seven of the twenty patients (35%) had a decrease in their overall risk rating scores as identified in Table 5.

Four of twenty (20%) did not exhibit any changes in their risk rating scores as identified in Table 5. Nine of the twenty patients (45%) were classified as low risk for aggressive behaviors and remained low throughout the seven consecutive days. These patients did not require a crisis prevention or risk management plan. Overall the DASA-IV Tool and corresponding plan showed 35% positive efficacy in identifying and managing aggressive behaviors in adult males with severe mental illness.

Table 6

Weekly Scores by Patient on the DASA-IV Tool

Patient	Range of weekly score
1	Moderate----------Low
2	Low
3	Low
4	High----------Low
5	Low
6	Moderate----------Low---------Moderate----------Low
7	Low
8	Low
9	Low
10	Low------Moderate---------Low
11	Moderate---------Low
12	Low------Moderate------Low
13	Low
14	Low--------High--------Low
15	Low
16	Low
17	High
18	Moderate
19	----------
20	Moderate
21	----------
22	Moderate----------High----------Moderate
23	----------

Results of the DASA-IV Tool with a range of weekly scores from day 1 to final score on day 7

Record of Aggression. All five aggressive incidents occurred on day 1 of the seven consecutive days of the assessment. Three of the five aggressive incidents were verbal aggression against persons, one of the five incidents was physical aggression against self,

and one of the five incidents was physical aggression against an object. There was no physical aggression to other persons during the four-week study period.

CHAPTER IV

DISCUSSION

For this doctoral capstone project, the project director determined if an evidence-based system approach that provides education to nursing staff on implementing a structured risk assessment tool for adult males with severe mental illness (SMI) improves identification and management of patients at risk for aggression in a psychiatric hospital. A structured risk assessment allows nursing staff to identify and manage aggressive behavior before aggression occurs. The DASA-IV tool focus is prevention, identification of warning signs to identify risk for imminent aggression and management of risk for aggression. While one cannot conclusively say that the DASA-IV tool was effective in preventing aggressive behaviors, it can be assumed from the results of this capstone project that the data collected on the DASA-IV tool was effective in identifying and managing risk for aggressive behaviors in adult males with SMI. Nursing staff were able to provide preventive interventions, implementation of a crisis prevention or risk management plan.

Of the potential twenty-three DASA-IV assessment tools completed during the study period, twenty of the tools were completed correctly. One of the twenty-three DASA-IV assessment tools was misplaced on the chart after initiation of the tool, and it was discovered two days after the initiation of the assessment. Therefore, two days had been skipped and the tool was eliminated. Two of the twenty-three DASA-IV assessment tools were eliminated prior to the completion of the study for unavoidable circumstances in which the patient could not be assessed for seven consecutive days. One patient's diagnosis changed and another patient was discharged in less than seven days.

Each patient assessment was completed for seven consecutive days, mid-day by the 7 a.m. to 3 p.m. nurse. The project director conducted retrospective reviews around 3 p.m. each day to ensure that the tools were completed correctly, plans were implemented for recommended DASA-IV scores, and aggressive behaviors were recorded in the designated area on the DASA-IV tool. Each patient with a rating of moderate aggression had a crisis prevention plan initiated on that day, and each patient with a rating of high aggression had a risk management plan initiated on that day. Once the plan was implemented, if the patient remained at the moderate or high risk for aggression, the corresponding plan was ongoing. While the results appear to indicate that the implementation of a crisis prevention plan for patients with a score of moderate risk for aggressive behaviors was effective, one patient identified as moderate risk for aggressive behaviors with a crisis prevention plan implemented still exhibited verbal aggression against others. Yet, the implementation of the risk management plan appeared to yield more positive results, as each patient that was identified as a high risk for aggressive behaviors received a risk management plan. It can be concluded that the identification of high risk for aggression with a risk management plan was effective in managing aggression as all incidents occurred on day 1; there was no further recording of aggression after the initiation of a risk management plan.

No patient with a classification of low risk for aggression was identified as having an aggressive incident. Also, aggressive behaviors were recorded prior to the initiation of the assessment on the following day for all patients with a reported and/or recorded aggressive behavior, by the 7 a.m. to 3 p.m. shift. There were five total aggressive incidents recorded during the four-week study period, and two of the five incidents were

a result of the aggression of one patient. Aggressive incidents were identified in two patients with moderate risk of aggression and two patients with high risk for imminent aggression. One patient identified as high risk for aggression had two incidents of aggression occur on the same day and around the same time. Therefore, there were a total of four patients responsible for incidents of aggression during the four-week study period. It may also be of clinical importance to consider the possibility of the DASA-IV to be effective in preventing the severity of aggressive behaviors, as most of the incidents were verbal aggression. There were two recorded incidents of aggression after the initiation of a crisis prevention plan for patients identified as moderate risk for imminent aggression. However, after the patient was rescored and identified as high risk for aggression and the risk management plan was implemented, there were no further recordings of aggression.

While a review of the literature suggested that from the nurses' perspectives aggressive behaviors in adult males with a diagnosis of severe mental illness are a direct result of the mental illness, these findings contradicts earlier literature in which the nurses identified the patient's mental illness as being the main cause for aggressive behaviors (Duxbury & Whittington, 2005). All patients that received the DASA-IV assessments had a diagnosis of severe mental illness; however, all of the patients did not receive the same score. It is also of importance to note that, initially, the majority of the patients (60%) were believed to be of low risk for aggression on day 1 in spite of their diagnosis of severe mental illness. Only one patient (0.05%) scored high for aggression all seven consecutive days. Nearly half of the patients (n=9; 45%) scored low risk for aggression all seven consecutive days, and only two of the twenty (10%) scored moderate risk for aggression for all seven consecutive days.

In regard to the usefulness of the DASA-IV tool in identifying and managing aggressive behaviors in adult males with severe mental illness in a psychiatric hospital, all of the nursing staff found the information collected on the tool to be useful in identifying and managing patients at moderate and high risk for imminent aggression in a psychiatric hospital. However, on the evaluation survey the nurses' response was neutral on the usefulness of implementing a risk management plan. It can be assumed that the nurses did not implement the plan long enough to state whether or not it was effective. An important possibility to consider is that the implementation of a risk management plan creates extra work for the nurses. Also another important factor to consider is the fact that the plan recommended interventions that are beyond the staffs control such as increasing the number of staff on the unit and pairing more experienced staff with the aggressive patient, which could potentially cause burn out if there is limited experienced staff to monitor the aggressive patient.

Prior to the implementation of the DASA-IV tool, nurses utilized clinical judgment alone to identify and manage aggressive behaviors. Shift reports from nursing staff usually only reported patient behaviors after an incident of aggression occurred and the treatment strategies utilized to manage the aggression. There were no reports of identifying potentially aggressive patients. The utilization of the DASA-IV tool to identify moderate and high risk for aggression allows nursing staff to implement early interventions for aggression. Also the DASA-IV tool increased staff's awareness of patients at increased risk of aggression, thus encouraging the implementation of patient-centered interventions such as therapeutic communication and a therapeutic environment.

The discussion of a crisis prevention plan with patients identified as moderate risk for imminent aggression not only improves communication, but also reiterates the patients' perspectives of strategies to prevent aggressive behaviors (Dickens et al., 2013; Duxbury & Whittington, 2005; Ilkiw-Lavalle & Grenyer, 2003; McPhaul et al., 2013; Ogloff & Daffern, 2006). Patient-centered interventions such as therapeutic communication can also inform patients that the staff is listening to them and value their perspectives. As identified in the literature, patients' perspectives of therapeutic communication and a therapeutic environment are very important aspects in preventing aggressive behaviors in adult males with SMI (Anderson &West, 2011; Cutcliffe & Riahi, 2013b). The implementation of the risk management plan for patients assessed as high risk for aggression created a safer environment by removing potentially dangerous objects, pairing more experienced staff with the aggressive patient, and also employing interventions such as allowing quiet time and creating a calmer environment for the patients. A systems approach that focused on the patients' as well as the staffs' perspectives of causes of aggressive behaviors was utilized in this project to identify and manage risk for aggression in adult males with SMI in a psychiatric hospital.

Limitations

Nursing staff working at psychiatric hospitals are accustomed to aggressive behaviors. Behaviors such as verbal aggression are often ignored and thought of as part of the patient's mental illness. It does not really appear to be classified as a form of aggression by the staff. Therefore, this could have contributed to the patients' low recording of aggressive incidents and low risk for aggressive behaviors during the study period. In spite of the patient's diagnosis of severe mental illness, the nursing staff

usually scored the patients as a significantly low risk for aggressive behaviors (60 to 75%). This could contribute to the evidence that patients' SMI is not the main cause of aggression.

The nurses' opinions of the patients' risk of aggressive behaviors appeared to be determined by prior incidents of aggression. For example, patients with a score of high risk of aggression initially usually scored moderate if no aggressive incidents were noted. Patients with moderate scores of aggression usually were changed to low if no aggression was noted. However, 1 patient that scored moderate for aggression was increased to high after he was noted to exhibit aggression. This indicates that the patients' behaviors tend to influence the nurses' opinions of their expected behavior and their scores on the DASA-IV.

The scoring on the following day may have been influenced by aggressive behaviors that occurred. For example, a patient may have a score of 0 for impulsivity, but if the patient has a recorded impulsive outburst, the score was automatically increased. Patient's behaviors that day influenced their scores. One patient had a score of 1 on the first day, but the remainder of the week his score was 0. However, on that day of the score of 1, the patient was refusing redirection and refused to get out of bed, which possibly influenced his score that day in that category. In other words, behaviors tended to influence the nurse's response the following day.

The small sample size of nursing staff ($N = 3$) used in the study is another study limitation that needs to be considered when reviewing these results. The study should be conducted on more than one unit to include a larger sample size of nurses. The short time frame in which the study was conducted (over a four-week study period) should also be

considered when reviewing these results. Future evaluation should look at conducting the study over a longer period of time.

Implications

It may be of clinical importance to note that the occurrence of aggressive incidents all occurred on day 1 of the admission. This could indicate that patients are more aggressive during the first few days of an admission. Also, it could indicate that the utilization of the DASA-IV tool and recommended crisis prevention plan for scores of moderate risk of aggressive behaviors and risk management plan for high risk of aggressive behaviors was successful in preventing aggressive behaviors from occurring. There were no injuries to staff and/or patients as result of aggressive behaviors during the project time period. More studies are needed to determine the likelihood of aggression to occur in the first few days of an admission and an examination of other factors that may decrease aggressive behaviors after being admitted to a psychiatric hospital. An alternative to possibility is that the patients did not have any medications in their systems the first few days of admission. Once the patient was medicated, aggressive behaviors decreased. In one study conducted in a psychiatric hospital, risk assessments were conducted twice a day for the first three days of admission (Abderhalden et al., 2008). The number of recorded incidents decreased during the first three days of admission. In contrast, the patient's high risk for aggression on the first few days of admission could contribute to the staff's reluctance to trust the patient due to their unfamiliarity with the patient, thus scoring them at a higher risk. In addition, the staff feeling more comfortable around the patients after getting to know them could have contributed to their decrease in patient ratings for aggressive behaviors as the days went on.

Despite the appearance of the results of the DASA-IV to be an effective tool for identifying and managing aggressive behaviors, the nurses indicated on the evaluation survey that they could not agree or disagree with the fact that the collected information on the DASA-IV tool was effective in identifying the need for a risk management and crisis prevention plan for high risk and moderate risk behaviors, respectively. It is not known why the nurses felt that the DASA-IV was successful in the identification and management of aggressive behaviors, yet provided neutral responses on the need to implement corresponding plans to assist in the management of aggressive behaviors. However, one possibility may be that the crisis prevention plan was already implemented on all newly admitted patients. If a patient was found to be at moderate risk for aggressive behaviors, the nurse was encouraged to discuss the crisis prevention plan with the patient. However, further education for nursing staff could be warranted as the results of the DASA-IV yielded positive results in terms of identifying and managing aggressive behaviors. Further evaluation in the project setting may include administering the DASA-IV over a three-day rather than a seven-day time period, on patients recently admitted and well-known patients, and utilizing an evidence-based crisis intervention plan instead of the current crisis intervention plan that the project facility is using. The results of this capstone project can be utilized in ongoing evaluations to assist with the implementation of structured risk assessment plans and updated hospital policies and evidence-based guidelines to prevent aggressive behaviors through the identification of high risk behaviors, thus, creating a safer environment for patients and staff.

Conclusion

Aggressive behaviors exhibited by patients with a serious mental illness (SMI) hospitalized in inpatient psychiatric hospitals are a challenging safety problem. Early identification of aggressive behaviors is vital to helping nursing staff develop proactive interventions that focus on prevention. The nursing staff found a structured risk assessment tool, the DASA-IV, useful in practice and information on the tool to be useful in identifying risk for imminent aggression and recording aggressive behaviors among adult males with SMI. Of the twenty risk assessments conducted, all were completed correctly by the nursing staff documenting the risk score and rating, implementing a crisis intervention or risk management plan based on the risk rating, and recording aggression.

The results of this project demonstrate that through an evidence-based system approach, the addition of a structured risk assessment tool for appraising risk for imminent aggression in a psychiatric hospital may assist nursing staff in the initiation of preventive interventions to manage aggressive behaviors.

APPENDIX A

DNP ESSENTIALS

Essential	How the essential are met
I. Scientific underpinnings for practice	This essential was met through the utilization of a review of the scientific evidence and the incorporation of the optimal healing environment framework and systems thinking/ system's approach to identify and manage aggressive behaviors in adult male's with severe mental illness in a psychiatric hospital.
II. Organizational and systems leadership for quality improvement and systems thinking	Through the implementation and evaluation of a structured risk assessment (DASA-IV) tool based on scientific findings from evidence-based practice literature, the capstone project improves the patients' quality of care while integrating a systems approach through improved therapeutic communication and therapeutic environment, to create a safer patient environment and prevent aggressive behaviors and injuries to patients and staff, thus improving the patients' overall healthcare outcomes.
III. Clinical scholarship (leadership) and analytical methods for evidence-based practice	The doctoral capstone project consisted of implementing a structured risk assessment (DASA-IV) tool to identify moderate and high risk behaviors with recommendations for a crisis prevention and risk management plan that are patient-centered to facilitate a safe environment for patients and staff while utilizing evidence-based practice with the ultimate goal of improving the patients' health outcomes.
IV. Information systems technology and patient care technology for the improvements and transformation of healthcare	The conceptual ability and technical skills utilized in designing and developing this capstone project, as well as execution of the evaluation plan involving data collection from the DASA-IV tools and patients' charts are examples of how this capstone project incorporates information systems technology and patient care technology for improvement and transformation of healthcare.
V. Healthcare policy for advocacy in healthcare	The capstone project involves critically analyzing aggressive behaviors in a psychiatric hospital through a systems approach that considers the patients' and staffs' perspectives in a systems approach implements a structured risk assessment tool (DASA-IV) to identify and manage aggressive behaviors with recommendations for patient-centered interventions proven to prevent aggressive behaviors in adult males with severe mental illness to prevent injuries and improve the patients' quality of care.
VI. Interpersonal collaboration for improving patient and population health outcomes	The utilization of a systems approach which implements a structured risk assessment to identify a need for patient-centered interventions, improve patient and staff interpersonal communication, and improve safety of the overall work environment using the optimal healing environment framework, thus improving patients' quality of care with the potential to change healthcare policies in the way in which aggression is currently identified and managed.
VII. Clinical prevention and population health for improving the nation's health	The education and utilization of The DASA-IV assessment tool to improve awareness, therapeutic communication, and create a safer work environment thus preventing injuries to patients and staff are examples of how this capstone project met this DNP essential.
VIII. Advance nursing practice	This essential was met through the education of nursing staff, implementation and evaluation of the DASA-IV structured risk

Essential	How the essential are met
	assessment tool with recommendations for patient-centered interventions which assists with the development and sustaining therapeutic relationships by incorporating a systems approach for adult males with severe mental illness in a psychiatric hospitals to prevent aggressive behaviors and facilitate optimal care and improve patient safety and overall outcomes.

APPENDIX B

EVALUATION PLAN

Goal	**Activities**	**Evaluation Results**
Provide education to nursing staff on implementing a structured risk assessment tool in order to identify risk for imminent aggression, manage risk for imminent aggression, and record aggressive behaviors among adult males with severe mental illness (SMI)	Educational session for nursing staff on the use of the DASA-IV tool, documenting results and scoring the tool, documenting aggressive behaviors, and initiating a plan to manage risk for aggression.	Five nurses attended the educational session.
Implement a structured risk assessment tool	Chart review to determine if nursing staff conducted an assessment of imminent risk for aggression over a four-week period on all patients admitted with a diagnosis of severe mental illness (SMI)	The nursing staff conducted a risk assessment on twenty patients admitted with a diagnosis of SMI over a four-week period.
Determine by retrospective chart review if the structured risk assessment tool is used by nursing staff to identify and manage patients with moderate or high risk for aggression	Retrospective Chart Review to determine if the nursing staff administered the tool correctly. Were patients identified at low, moderate, and high risk for aggressive behaviors? Was a crisis prevention plan implemented and discussed with the patients scoring 1 or 2 on the DASA-IV tool? Was a risk management plan implemented for patients with a score of 3 or greater on the DASA-IV?	The DASA-IV was administered correctly, plans were implemented for recommended DASA-IV scores, and aggressive behaviors were recorded in the designated area on the DASA-IV tools. Nine of the twenty patients (45%) were scored at a low risk and remained low throughout the seven consecutive days; seven of the twenty patients (35%) were scored at moderate risk, and each of the seven patients had a crisis prevention plan implemented; and four of the twenty patients scored

Goal	Activities	Evaluation Results
		high, and each of the four patients had a risk management plan implemented. There were five recorded incidents of aggression (all on day 1).
Evaluate nursing staff's perspective of the usefulness of the structured DASA-IV in a psychiatric hospital.	At the end of the four-week study period, a short anonymous survey was administered to all study participants	All of the nurses agreed with questions that the information collected on the tool to be useful for identifying the patients as being moderate and high risk for imminent aggression, recording the patient's aggressive behaviors and relatively easy to use, overall the DASA-IV was useful and they would like to continue it in their practice. Furthermore, the nurses agreed and did not agree or disagree with the usefulness of the information collected on the tool to identify a need for a crisis prevention or risk management plan.

APPENDIX C

MSH IRB APPROVAL

MISSISSIPPI STATE HOSPITAL

P.O. BOX 157-A, WHITFIELD, MS 39193 (601) 351-8000 WWW.MSH.STATE.MS.US

James G. Chastain, Director

Joseph Kastner, Ph.D.
Chair
Institutional Review Board
Building 51
Mississippi State Hospital
Whitfield, MS 39193

Telephone: (601) 351-8010
Telecopier: (601) 351-8086
Electronic email: joseph.kastner@msh.state.ms.us

July 21, 2014

Mitzie Jenkins
Mississippi State Hospital
Building 23
P.O. Box 157-A
Whitfield, MS 39193

Dear Ms. Jenkins:

Your protocol titled **"Integrating a System Approach to Identify and Manage Aggressive Behaviors in Adult Males with Severe Mental Illness in a Psychiatric Hospital"** was approved by Expedited Review. Your protocol has been approved for 12 months from the above date.

Please sign the enclosed confidentiality and data use agreement and send it to me. Also, please keep the Board updated on the progress of your research and inform me prior to any changes in procedures or if any adverse outcomes occur. All ongoing research will be reviewed at least annually. Please send me information of any papers, publications or presentations that result from this research.

Sincerely,

Joseph Kastner, Ph.D.
Chair of MSH Institutional Review Board
Mississippi State Hospital
Whitfield, MS 39193

APPENDIX D

M. DAFFERN APPROVAL LETTER

Centre for Forensic Behavioural Science

Swinburne University of Technology

505 Hoddle Street
Clifton Hill Victoria 3068
Australia

T +61 3 **9947 2600**
F + 61 3 9947 2650

22nd July 2014

Mitzie Jenkins, PMHNP-BC
Mississippi State Hospital

Dear Ms Jenkins,

Thank you for your correspondence regarding your use of the Dynamic Appraisal of Situational Aggression in a study concerning aggressive and violent behaviors in adult males with severe mental illness on an inpatient psychiatric unit. I am happy for you to use the DASA for this purpose.

Yours sincerely,

Michael Daffern
Professor in Clinical Forensic Psychology
Centre for Forensic Behavioural Science
Swinburne University of Technology

APPENDIX E

DASA- IV Tool

Forensicare

DYNAMIC APPRAISAL OF SITUATIONAL AGGRESSION

Centre for Forensic Behavioural Science
Monash University

Name:_____

Week beginning:____/____/____

The following ratings are based on your knowledge and observations of the patient during the PREVIOUS 24 HOURS. Each item/subscale are scored as 1 for an increase in the behaviour described. (eg. on an irritability subscale being more irritable is scored as 1).	Monday (Circle One)	Tuesday (Circle One)	Wednesday (Circle One)	Thursday (Circle One)	Friday (Circle One)	Saturday (Circle One)	Sunday (Circle One)
Irritability							
The patient is easily annoyed or angered. The patient is unable to tolerate the presence of others.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Impulsivity							
The patient displays behavioural and affective instability (i.e., dramatic fluctuations in mood, or general demeanour; inability to remain composed and directed).	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Unwillingness to Follow Directions							
The patient tends to become angry or aggressive when they are asked to adhere to treatment or to the ward's routine.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Sensitivity to Perceived Provocation							
The patient tends to see other people's actions as deliberate and harmful, they may misinterpret other people's behaviour or respond with anger in a disproportionate manner to the extent of provocation.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Easily Angered When Requests are Denied							
The patient tends to be intolerant, or is easily angered when they make a request that is denied or when they are asked to wait.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Negative Attitudes							
The patient displays antisocial and negative attitudes and beliefs which may relate to violence and aggression.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Verbal Threats							
The patient displayed a verbal outburst, which is more than just a raised voice, and where there is a definite intent to intimidate or threaten another person.	0 1	0 1	0 1	0 1	0 1	0 1	0 1
Total	/7	/7	/7	/7	/7	/7	/7
Final risk rating							
Based on the DASA Scores and clinical assessment rate (H) high, (M) medium or (L) low risk for the next 24 hours.							
Record of aggression							
During the previous 24 hours has the patient behaved aggressively in any of the following ways? Please mark with a cross in the appropriate box.							
Physical Aggression against OBJECTS							
Slams door, throws objects down, kicks furniture, breaks objects, smashes windows, sets fires, throws objects.							
Verbal Aggression against OTHER PEOPLE							
Shouts angrily, insults, curses violently, uses foul language in anger, or makes clear threats of violence to others.							
Physical Aggression against OTHER PEOPLE							
Makes threatening gesture, swings at people, grabs at clothes, strikes, kicks, pushes, pulls hair, or attacks others.							

APPENDIX F

USM IRB APPROVAL

THE UNIVERSITY OF
SOUTHERN MISSISSIPPI.

INSTITUTIONAL REVIEW BOARD
118 College Drive #5147 | Hattiesburg, MS 39406-0001
Phone: 601.266.5997 | Fax: 601.266.4377 | www.usm.edu/research/institutional.review.board

NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
  Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 14081801
PROJECT TITLE: Integrating a System Approach to Identify and Manage Aggressive Behaviors in Adult Males with Severe Mental Illness in a Psychiatric Hospital
PROJECT TYPE: New Project
RESEARCHER(S): Mitzie Jenkins
COLLEGE/DIVISION: College of Nursing
DEPARTMENT: System Leadership and Health Outcomes
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Expedited Review Approval
PERIOD OF APPROVAL: 08/18/2014 to 08/17/2015

Lawrence A. Hosman, Ph.D.
Institutional Review Board

APPENDIX G

RECRUITMENT FLYER

INTEGRATING A SYSTEM APPROACH TO IDENTIFY AND MANAGE AGGRESSIVE BEHAVIORS IN ADULT MALES WITH SEVERE MENTAL ILLNESS IN A PSYCHIATRIC HOSPITAL

Are you a permanently assigned "A" shift nurse on building 203/ ward 3?

If the answer is **YES…**

Mitzie Jenkins, PMHNP, would like to invite you to participate in a doctoral capstone project on the unit.

THE PURPOSE of this project is to measure nursing staff's perspective of the usefulness of a short-term structured risk assessment tool (DASA-IV) in identifying and managing risk for aggressive behaviors in adult males in a psychiatric hospital.

- Conducted over a 4 week period, the tool will take less than 5 minutes to complete.
- **There will be no cost involved.**
- The data generated through participation in this project could benefit both the staff and the patients as it might lead to an adaptation in the way in which aggression is currently being managed on the unit.
- The nurse manager will provide date and time of project recruitment presentation.

To learn more about the project,

Please call Mitzie Jenkins, PMHNP at 601-351-8311 or 601-616-4275

USM IRB Approval Date 8/18/2014

APPENDIX H

ORAL PRESENTATION

ORI | Office of Research Integrity

INSTITUTIONAL REVIEW BOARD

ORAL PRESENTATION OF RESEARCH PROCEDURES

ORAL PRESENTATION OF RESEARCH PROCEDURES

The information outlined in this document must be presented orally to all potential research participants before consent is obtained.

- A completed version of this oral presentation (sans signatures) must be submitted to the IRB for approval.
- The participants should be made aware of the IRB overview of the project and be given contact information for various individuals in case they have any questions.
- Copies of the oral presentation should be provided to all participants.
- Witnesses to the oral presentations must be someone other than the Principal Investigator.
- Unless a waiver of documentation of consent is requested from and granted by the IRB, all oral presentations must be accompanied by a short form consent.

Last Edited June 2nd, 2014

Today's date:7/14/2014		
PROJECT INFORMATION		
Project Title: Integrating a System Approach to Identify and Manage Aggressive Behaviors in Adult Males with Severe Mental Illness in a Psychiatric Hospital.		
Principal Investigator: Mitzie Jenkins	Phone: 601-616-4275	Email: mitzie.jenkins@eagles.usm.edu
College: Nursing	Department: Systems Leadership and Health Outcomes	

ORAL PRESENTATION PROCEDURES

1. **Purpose**:

The purpose of the doctoral capstone project is to: a) provide education to nursing staff on implementing a structured risk assessment tool in order to identify risk for imminent aggression, manage risk for imminent aggression, and record aggressive behaviors among adult males with serious mental illness (SMI); b) implement the structured risk assessment tool; c) determine by retrospective chart review if the structured risk assessment tool is used by nursing staff to identify and manage patients with moderate or high risk for aggression; and d) evaluate nursing staff's perspective of the usefulness of the structured risk assessment tool on a unit in a psychiatric hospital.

2. **Description of Study:**

A structured risk assessment tool (Dynamic Appraisal of Situational Aggression- Inpatient Version [DASA-IV]) will be utilized in the project. The DASA-IV is a 7 point rating scale designed to identify the risk of aggressive behaviors among patients in acute psychiatric settings and is based on knowledge and observations of patients during the previous 24 hour period. Nursing staff participants will be provided instructions on how to conduct a risk assessment for aggression on the adult male unit.

After obtaining informed consent from participants, a brief educational session on the use of the DASA-IV tool, the importance of documenting results and scoring of the DASA-IV tool, documenting aggressive behaviors, and initiating a plan to manage risk for aggression if the patient is identified as moderate or high risk for aggression. Education will be provided on implementing a individual crisis prevention plan on patients that score 1 or 2 on the DASA-IV, indicating moderate risk. An overview of implementing a risk management

plan for patients that score 3 or greater on the DASA-IV, indicating high risk will be discussed.

After the educational session, nursing staff will conduct a continual assessment over a 4 week period in which the DASA-IV will be completed by the 7 a.m. - 3p.m. nursing staff for seven days on all patients admitted with a diagnosis of severe mental illness (SMI), schizophrenia, schizoaffective disorders, schizopheniform disorders, and/or any thought, mood, or substance abuse disorders with psychosis as defined in the DSM-IV. The assessment will be completed mid-day on the 7a.m -3p.m shift. Patients with a score of 0 are considered low risk, scores of 1-2 are considered moderate risk and patients will receive a crisis prevention plan to be implemented and discussed with the patient, and scores of 3 or greater are considered high risk and will receive a risk management plan to prevent aggressive behaviors.

The 7a.m. - 3p.m participating nursing staff will report results of 1 or greater to the oncoming 3p.m -11p.m nursing staff during shift reports. The 3p.m - 11p.m nursing staff will pass this information on in shift report to the 11p.m - 7 a.m nursing staff. The patients will be rescored the following day around the same time (mid-day) by the 7a.m - 3p.m nursing staff. If a patient with a completed DASA-IV exhibits verbal or physical aggression to self, people, or objects, the incident will be recorded in the designated area on the DASA-IV tool, prior to the 7am-3pm nursing staff conducting the scheduled DASA-IV daily assessement. If a patient with a completed DASA-IV scores low risk and exhibits aggressive behaviors towards self, people, or objects, the behavior should be documented and the risk management plan implemented to prevent further aggressive behaviors. This patient will also need to be reassessed on a separate DASA-IV form, by the 7 a.m- 3 p.m nursing staff. The assessment will take less than 5 minutes to complete on each patient; therefore, there will be no restrictions on the normal activity of the participants and patients.

The PI will frequent the unit every 72 hours to conduct a retrospective chart review on newly admitted patients and determine if the DASA-IV is being recorded and scored correctly, to monitor the implementation of the crisis prevention plan for scores of moderate risk and risk management plan for scores of high risk. The PI will also check to see if aggressive behaviors are being documented on the DASA-IV, as it is imperative that the 3p.m.-11p.m. and 11p.m. - 7a.m. nursing staff document, as well as report aggressive and violent behaviors to the oncoming shift.

At the conclusion of the 4 week project period, all participating nursing staff will be administered a survey to identify whether they felt that the DASA-IV tool was useful in identification of patients at moderate or high risk for aggressive behaviors and implementation of a crisis prevention plan or risk management plan to manage risk for aggressive behaviors.

3. **Benefits:**

The data generated through participation in this project could potentially benefit the nursing staff and the patients as it might lead to a change in practice on how aggression is currently being prevented and managed on the unit. It can also contribute to the development of new policies to ensure safety of both the patients and the staff members. The development of new safety policies could also benefit the organization. However, no participants will be paid to take part in this project. There will be no cost involved.

4. **Risks:**

There are minimal risks of harm to participants with this project. Data is anonymous and cannot be associated with individual subjects; therefore, loss of privacy and breach of confidentiality is not a risk. Participants may experience psychological discomfort when completing the structured risk assessment tool due to recollection of an incident where the participant was the victim of the patient related aggression or violence. However, if participants should feel discomfort when completing the structured risk assessment tool due to recollection of an incident where the participant was the victim of the patient related aggression, the project director encourages the participant to call her at 601-351-8311. A formal interview will be conducted to determined if a formal referral to a qualified psychotherapist to help resolve unresolved trauma (should the participant desires to do so).

5. **Confidentiality:**

To ensure confidentiality and anonymity, participant information will be protected through the use of codes

assigned by the project investigator on a data collection form.The data entered on the data collection form will not contain any identifying information. Data will be recorded and summarized by the PI so that subjects cannot be identified, directly, or through identifiers linked to the subjects. Confidentiality and anonymity will be protected by placing consent forms and all data collected in a locked filebox that will be kept by the PI and only the PI has access to the data in the locked filebox and drawer.

6. **Alternative Procedures:**

Participation in the project is entirely voluntary and if participants select not to participate they will not be penalized in any way. Participants may withdraw from the project at any time without penalty, prejudice, or loss of benefits, including but not limited to employment at the psychiatric hospital.

7. **Participant's Assurance:**

This project has been reviewed by the Institutional Review Board, which ensures that research projects involving human subjects follow federal regulations.

Any questions or concerns about rights as a research participant should be directed to the Manager of the IRB at 601-266-5997.Participation in this project is completely voluntary, and participants may withdraw from this study at any time without penalty, prejudice, or loss of benefits.

Any questions about the research should be directed to the Principal Investigator using the contact information provided in Project Information Section above.

PRINCIPAL INVESTIGATOR AUTHORIZATION

By signing my name below, I attest that the procedures for oral presentation described above were followed.

_____	_____
Principal Investigator	**Witness to Oral Presentation**
_____	_____
Date	**Date**

APPENDIX I

INFORMED CONSENT

ORI | Office of Research Integrity

INSTITUTIONAL REVIEW BOARD

SHORT FORM CONSENT

SHORT FORM CONSENT PROCEDURES

This document must be completed and signed by each potential research participant before consent is obtained.

- All potential research participants must be presented with the information detailed in the Oral Procedures before being signing the short form consent.
- The Project Information section should be completed by the Principal Investigator before submitting this form for IRB approval.
- Copies of the signed short form consent should be provided to all participants.
- The witness to consent must be someone other than the Principal Investigator or anyone else on the research team.

Last Edited June 2nd, 2014

Today's date: 7/14/2014

PROJECT INFORMATION

Project Title: Integrating a System Approach to Identify and Manage Aggressive Behaviors in Adult Males with Severe Mental Illness in a Psychiatric Hospital.

Principal Investigator: Mitzie Jenkins	Phone: 601-616-4275	Email: mitzie.jenkins@eagles.usm.edu
College: Nursing	Department: Systems Leadership and Health Outcomes	

CONSENT TO PARTICIPATE IN RESEARCH

Participant's Name: _____

Consent is hereby given to participate in this research project. All procedures and/or investigations to be followed and their purpose, including any experimental procedures, were explained. Information was given about all benefits, risks, inconveniences, or discomforts that might be expected.

The opportunity to ask questions regarding the research and procedures was given. Participation in the project is completely voluntary, and participants may withdraw at any time without penalty, prejudice, or loss of benefits. All personal information is strictly confidential, and no names will be disclosed. Any new information that develops during the project will be provided if that information may affect the willingness to continue participation in the project.

Questions concerning the research, at any time during or after the project, should be directed to the Principal Investigator using the contact information provided above. This project and this consent form have been reviewed by the Institutional Review Board, which ensures that research projects involving human subjects follow federal regulations. Any questions or concerns about rights as a research participant should be directed to the Chair of the Institutional Review Board, The University of Southern Mississippi, 118 College Drive #5147, Hattiesburg, MS 39406-0001, (601) 266-5997.

_____	_____
Research Participant	**Witness to Consent**
_____	_____
Date	**Date**

APPENDIX J

DATA COLLECTION TOOL

Name: (# in consecutive order)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Score							
Risk Rating							
Record of Aggression							
Crisis Prevention Plan							
Risk Management Plan							

LEGEND

Crisis Prevention PLAN:	**SCORE**	**RISK RATING:**	**RECORD OF AGGRESSION:**
Y- YES	**Y**- YES	**L-** Low	**VAP**- Verbal/ Aggression Person
N- NO	**N-** NO	**M**- Moderate	**PAS**- Physical/Aggression Self
		H- High	**PAP**- Physical/ Aggression Person
			PAO- Physical/Aggression Object

Risk Management PLAN:

Y- YES

N- NO

APPENDIX K

SURVEY

Title: RN/ LPN **Gender:** Male/ Female **Age:** 25- 35 / 36- 45/ 46- 55/ 56- 65/ above 65

This is a short anonymous survey used to evaluate if the DASA-IV tool was useful in assessing and managing aggressive behaviors. Please rate your response to the following questions by circling the answer that best describes your opinion.

5 = Definitely Yes; 4 = Yes; 3 = Neutral; 2= No; and 1 = Definitely No

1. During the 4 weeks you have been using the DASA-IV tool, have you found the information collected on the tool to be useful in identifying patients identified as moderate risk for imminent aggression?

   5 4 3 2 1

2. During the 4 weeks you have been using the DASA-IV tool, have you found the information collected on the tool to be useful in identifying patients identified as high risk for imminent aggression?

   5 4 3 2 1

3. During the 4 weeks you have been using the DASA-IV tool, have you found the information collected on the tool to be useful in identifying the need for the implementation of a crisis intervention plan with patients identified as moderate risk for imminent aggression?

   5 4 3 2 1

4. During the 4 weeks you have been using the DASA-IV tool, have you found the information collected on the tool to be useful in the implementation of a risk management plan with patients identified as high risk for imminent aggression?

   5 4 3 2 1

5. During the 4 weeks you have been using the DASA-IV tool, have you found the information collected on the tool to be useful in recording patient's aggressive behaviors?

   5 4 3 2 1

6. Did you find the DASA-IV to be easy to use?

5 4 3 2 1

7. Overall, did you find the DASA to be useful to your practice?

5 4 3 2 1

8. Would you like to continue to use the DASA-IV in your practice?

5 4 3 2 1

APPENDIX L

WAIVER

ORI | Office of Research Integrity

INSTITUTIONAL REVIEW BOARD

REQUEST FOR WAIVER OR ALTERATION OF AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN RESEARCH FORM

REQUEST FOR WAIVER PROCEDURES
This form should be used only to seek IRB approval of a waiver or alteration regarding the federal "Privacy Rule" requirement that Protected Health Information (PHI) may be used or disclosed only with a research participant's signed Authorization. Researchers may not use or disclose PHI absent either participants' signed Authorizations or an approved waiver. Last edited: April 10th, 2014

Today's date:7/14/14		
PROJECT INFORMATION		
Project Title: Integrating a System Approach to Identify and Manage Aggressive Behaviors in Adult Males with Severe Mental Illness in a Psychiatric Hospital.		Protocol #:
Principal Investigator: Mitzie Jenkins	Phone: 601-616-4275	Email: mitzie.jenkins@eagles.usm.edu
Indicate type of waiver requested: ☐Partial Waiver ☒Full Waiver ☐Alteration	List the source(s) of the PHI, being as specific as possible. Over a four week period, a retrospective chart review will be conducted on adult males with severe mental illness admitted to a psychiatric hospital to include: completion of DASA-IV tool, a plan to manage risk for aggression, and record aggressive behaviors.	
Describe the PHI being used or recorded. (e.g., test results, diagnosis, medical history). De-identified data from the DASA-IV tool and retrospective chart review to determine if nursing staff documented the results and score of the DASA-IV tool; aggressive behaviors; and a plan to manage risk for aggression if the patient is identified as moderate or high risk for aggression for the first seven days of admission.		
Explain how the PHI will be protected, so far as possible, from improper or unauthorized use or disclosure. Health information will not be individually identified and will include de-indentified health information for statistical analysis. No identifying information will be collected.		
Explain why the research could not practicably be conducted without use or disclosure of the PHI. One of the project's goals is for nursing staff to implement a structured risk assessment tool to identify risk for imminent aggression, manage risk for imminent aggression, and record aggessive behaviors among adult males with serious mental illness (SMI) in a psychiatric hospital.		
Explain why the research could not practicably be conducted without the waiver or alteration of authorization. The principal investigator will determine by retrospective chart review if the structured risk assessment tool is used by nursing staff to identify and manage patients with moderate or high risk for aggression and record aggressive behaviors.		

By typing my name below, I acknowledge that I will not use or disclose participants' PHI except in the manner indicated above. **Mitzie Jenkins** _____ **Principal Investigator** **7/14/14** _____ **Date**

APPENDIX M

LITERATURE REVIEW TABLE

Reference	**Problem**	**Intervention**	**Comparator**	**Outcome**	**Timing**	**Setting**
Abderhalden, c, 2007	Question as to whether there are frequent aggressive incidents on acute admission wards.	Prospective multicentric study in twenty-four acute admission wards in twelve psychiatric hospitals To describe the frequency and severity of aggressive incidents in acute psychiatric ward in the German speaking part of Switzerland.	Prospective multicentric study on twenty-four acute admission wards in twelve psychiatric hospitals in the Switzerland. Aggressive incidents were recorded by the revised staff observation aggressive scale and checked the data collection for underreporting .	Outcome-aggressive incidents in acute admission wards are a frequent and serious problem.	Observation period of three months per ward (twenty-four X three months) totaling seventy-two months	Twelve psychiatric hospitals in German speaking part of Switzerland
Cutcliffe & Riahi, 2013a & b	Too frequent occur-rence of aggression and violence yet attempts to reduce in mental healthcare focus on only one or two aspects	A two-part paper that recognized a wide range of phenomena, synthesized, and explored empirical evidence, and begins to consider the application of a systems model to better inform individuals and organization-al response to aggressive	Multifaceted Systems model of aggression and violence versus models which focus on one or two aspects	Intraper-sonal service users literature rarely consistent with those actually living in the environ-ment (perspec-tives are never considered) a wide range of phenomena	N/A	Australia

Reference	Problem	Intervention	Comparator	Outcome	Timing	Setting
		and violent behaviors in mental healthcare.		have impact on the rates of aggressive and violent in mental healthcare is multidimen sional and a complex problem.		
Griffin, Daffern, & Godber, 2013	Structured violence risk assessmen ts are not being used in non-forensic mental health settings	Two pilot studies, each one month long in duration	Comparison the predictive validity of the DASA-IV (482) with unaided clinical judgment (997)	DASA-IV (valid measure) total scores predicted aggression significant-ly better than unaided clinical risk ratings.	Two months	A large regional teaching hospital in Victoria, Australia
Mahoney et al., 2009	Purpose-to provide a framewor k to organize care in a holistic manner that supports positive health outcomes	Intervention-reconceptual-ization of the therapeutic milieu/frame-work	Comparison of safety issues as the focus of the milieu to expanded new therapeutic milieu which links important aspects of the therapeutic milieu with thee framework from the optimal healing environment literature.	Proposal of reconceptu alization of the therapeutic milieu of an optimal healing environ-ment	N/A	N/A
Ogloff, J., & Daffern, M.	Appraisal tools used	Study was designed to	Assessment supported by	The combina-	Twenty-four-hour increments,	The secure inpatient

Reference	Problem	Intervention	Comparator	Outcome	Timing	Setting
(2006)	to identify modifi-able aspects of aggression prone environ-ments often have dimin-ished ability to inform day-to-day treatment and manage-ment decisions are limited	identify existing and novel risk factors that would assist staff to identify and manage the risk from aggression in psychiatric inpatient populations	structured risk measures to clinical judgments based only on nurses' clinical experience and knowledge of the patient alone.	tion of seven test items emerged that were maximally effective at identifying acute psychiatric patients at risk for engaging in inpatient violence within twenty-four hours; to develop the Dynamic Appraisal of Situational Aggression	ratings were made by designated nurse every shift, three times daily (at 7 a.m., 1 p.m., & 9 p.m.). Six-month study	hospital of the Victorian Institute of Forensic Mental Health (Forensi-care), Thomas Embling Hospital

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